AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL RECORDS AND EDUCATIONAL INFORMATION

Student: _____ DOB: _____

Address: _____

I hereby authorize the Lawrence Public Schools/Special Learning Services Department to exchange/obtain educational/health information on the above named with:

_____

(Name of agency, physician, school district, etc.)

_____

(Address) (City) (State) (Zip Code)

Education Record/Information to be disclosed consists of:

Psychological _____ IEP _____

Home Assessment _____ Speech/OT/PT/APE/Counseling Assessment_____

Educational Assessment_____

This information will be used for the following purpose(s)

1. Educational evaluation and program planning
2. Planning for services and treatment in school
3. Other:

_____ _____

Authorization

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that educational records, once received by the school district, may not be protected by the HIPPA Privacy Rule, but will become education records protected by the Family Educational Rights to Privacy Act. I also understand that if I refuse to sign such refusal will not interfere with my child's ability to obtain educational services.

_____ _____

Parent/Guardian/Educational Surrogate Parent/Student over 18 years old **Date**

Revised: 12.02.19