SCHOOL DISTRICT NAME

SECTION 504 CONSENT TO RELEASE/REQUEST CONFIDENTIAL RECORDS

Student: _____ Campus: _____ Date: _____

Student ID: _____ Grade: _____ Date of Birth: _____

For the purpose of evaluation/program planning, I hereby give my permission for the _____ School District to release/request specified records containing confidential information regarding the above named student to/from the following.

_____
Physician Name and Title/Certification

_____
Address of Physician

_____ _____ _____
City State Zip Code

_____ _____
Phone number Fax number

TO BE COMPLETED BY CAMPUS

Records Requested

- □ Physician Information Report
- □ Medical Assessments
- □ Psychological Evaluation
- □ Permission for school/district staff to talk to medical personnel.
- □ Other _____

Parent/Guardian or Adult Student:

Your signature below indicates consent to request records.

- I have been fully informed and understand the school's request for my consent as described above. The information will be requested upon receipt of my written consent.
- I understand my consent is voluntary and may be revoked at any time.
- I understand that once these records are received by the school district, they may be protected as educational records by FERPA rather than HIPPA.
- Payment for any fees for processing the transfer of records will require prior written authorization from _____ School District.

_____ _____
Signature of Parent/Guardian or Adult Student Date

Date faxed to physician: _____

<u>Physician</u>: Fax records back to:

_____ _____ _____ _____
Name Campus Phone number Fax number

Original: 504 Folder Copy: Parent/Guardian Copy: Physician