School District of Superior
3025 Tower Ave
Superior, WI 54880
715-384-8704
FAX: 715-394-2874

REQUEST TO RELEASE OR OBTAIN STUDENT RECORDS

Patient/Student Information:

Name:

Date of Birth:

I hereby authorize the School District of Superior, 3025 Tower Ave, 715-394-8704 to release ☒ obtain ☐ my IEP information/records for the purpose listed below to:

Description
The health information to be disclosed consists of:
☐ Medical and/or related health records
☒ Psychological evaluations, behavioral assessments and/or social work reports
☐ Appropriate agency reports (if any)

The Education Information to be Disclosed of Consists of:

IEP

Authorization
This authorization is valid from _____ to _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25(2m)(a)(b) and 146.82-146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____ _____
Parent Signature Date

_____ _____
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Wisconsin, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for HIV/AIDS, and family planning services.

Revised: October 2003