



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 or 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.