Lansing School District

Request For Protected Information

Child's Information

Child's Name: Date of Birth:

Parent/Guardian's Name: Phone Number:

Purpose

The purpose of this request is to facilitate the coordination and continuity of medical care. In addition, it may be used to assist in the determination of your child's eligibility for Special Education and/or to plan and provide services determined through the multidisciplinary team process.

Provider(s) Authorized to Share Information with the School District

The medical provider(s) and/or advocate listed below have permission to share the specific information listed about my child. Specific information may include medical, education, and discipline records; case notes, discharge summaries, etc.

Provider:	**Address, Phone Number, Fax Number:**
Provider:	**Address, Phone Number, Fax Number:**
Provider:	**Address, Phone Number, Fax Number:**

Information May be Released to:

Name of School: Lansing School District Address:

Phone Number: Fax Number:

Principal: Teacher:

School Nurse: Other:

Authorization

My signature below means I understand that:

- My authorization to allow the sharing of information about my child is voluntary
- Information regarding behavioral and mental health services or communicable disease
- Information received under this authorization becomes part of my child's educational record, is protected by Family Education Rights and Privacy (FERPA), and will no longer be protected by Health Insurance Portability and Accountability Act (HIPAA).
- Information may be re-disclosed by the school district as part of the educational record protected by FERPA.
- I may refuse to sign this authorization.
  - Refusal to sign may affect the ability of the district to obtain information necessary to demonstrate that my child meets Special Education eligibility criteria.
  - If my child is found eligible for Special Education, refusal to sign this authorization will not affect my affect my ability to obtain services. However, the information obtained can help provide services that are individualized for my child.
- I may revoke or cancel authorization at any time, without penalty, by notifying the district in writing. Information that has already been shared based on this authorization cannot be taken back.

I have read and understand this authorization form (or it has been read to me in a language I understand) and:

☐ I authorize the above listed medical provider(s) or designee(s) to engage in verbal, written, and/or electronic communication in order to share specified records and information.

OR

☐ I do not wish to have any information shared at this time.

Signature of Parent/Guardian: Relationship to Child: Date: