Mid Valley School District

52 Underwood Road * Throop, PA 18512

CONSENT TO RELEASE/REQUEST CONFIDENTIAL RECORDS

Student: _____ Building: _____ Date: _____

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

For the purpose of evaluation/program planning, I hereby give my permission for the Mid Valley 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**

Completed by building
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 the **Mid Valley School District**.

_____ _____

Signature of Parent/Guardian or Adult Student **Date**

Date faxed/emailed to physician: _____

Physician: Fax/email records back to:

_____ _____ _____ _____

Name **Building Location** **Phone number** **Fax number/email**

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