Cedar Rapids Community School District

RELEASE OF INFORMATION AUTHORIZATION

Child/Student_____
(Legal Last Name) (First Name) (Middle Name)

Birthdate_____ **Social Security Number**_____

I, the undersigned, hereby authorize_____

_____
(Name and address of person or agency)

to send and/or exchange information (verbal and/or written) to/with:

_____
(CRCSD Personnel)

Information Requested: _____

_____

Purpose of release:

_____

_____

This permission is good for one (1) year from the date signed.

I understand_____
(Contact Person) (Position) (Agency) (Phone)

can direct me to the shared information upon request. I understand that I may revoke this consent at any time by sending a written notice to contact person listed above. I understand that the revocation will not apply to disclosure made prior to receiving the written notice. This authorization will automatically expire one year from the date of signature, except as specified:_____ At that time no express revocation shall be needed to terminate my consent. Required for HIPAA entities: I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand that if the recipient of this information is not a health care provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure.

Parent/Legal Guardian Signature_____ **Date**_____

Student Signature_____ **Date**_____

Specific Authorization for Release of Information Protected by State and Federal Law:

My signature authorizes release of all information relating to (check appropriate area):
_____Mental Health _____Substance Abuse_____HIV/AIDS related
NOTE: In order for this information to be released, you must sign below and above.

Parent/Legal Guardian Signature_____ **Date**_____

Student Signature_____ **Date**_____