

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release". The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication/somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis. Stats., DHS 92.03-92.06 Wis. Adm. Code.

Person Whose Records Will be Released (Record Subject)

Student Name: _____ Date of Birth: _____

Guardian Name: _____

Name – (Information May be Released To)

Organization
Plymouth School District

Address _____

City, State, Zip Code _____

Phone: _____

Name & Address – Agency/Organization I Authorize to Release Information

Specific Description of Records Authorized for Release (Include dates of records, if applicable)

Medical and/or related health records

Psychological/ Psychiatric evaluations or social work reports

Appropriate agency reports

Others (specify) _____

Purpose or Need for Release of Information (Be Specific)

Educational evaluation and planning

Coordination of services

Other (specify) _____

Understandings

This authorization is voluntary.

The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.

I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information.

Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Choose One

☐ Authorization expires as of _____ (Date).

☐ Authorization expires _____ month(s) from the date I sign this authorization.

☐ Authorization expires after the following action takes place: _____

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

SIGNATURE - Person Whose Records Will be Released (Record Subject)

Date Signed _____

SIGNATURE - Other Person Legally Authorized to Consent to Disclosure

Title or Relationship to Record Subject

Date Signed _____