** Kalispell School District #5**

 **Kalispell, MT**

**Authorization for Exchange of Confidential Student Information**

|  |  |  |
| --- | --- | --- |
| Student Name: | Grade: | Home Phone: |
| Birth Date: | Age: | Day Phone: |
| Address: |  |  |
| City: | State: | Zip Code: |

**A. Names of parties authorized to exchange information:**

 I authorize:

 Name Title

 Organization

 Address City State Zip Code

 Phone Number Fax Number

  **(check either box or both, as needed) to release information to to obtain information from:**

 Name Title

 Organization

 Address City State Zip Code

 Phone Number Fax Number

**B. Information to be released:**

Official School Record Health Record Medical Report

Counseling Record Psychological Record Special Education Record Transcripts Social Work Report Chemical Abuse/Dependency Report Teacher, Counselor, Staff Observations

Other (specify)

**C. Purpose of this request:**

 **This authorization takes effect the day you sign it, and:**

**D. Effective Date of Authorization**: expires after the requested information is received.

continues until (not to exceed 12 months).

By signing authorization, I understand that parties named above are permitted to exchange written and verbal information regarding my child. The parties may also accept a photocopy of this release form and give it the same full force and effect as the original. I further understand that I may revoke this authorization in writing at any time by providing a copy of my revocation to the parties named above. The information used or disclosed under this release might be disclosed by the school district as an educational record, pursuant to FERPA, and might no longer be protected by HIPAA.

Parent Signature Date

\*It is intended that this Authorization meets the requirements under the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Copy to the confidential folder, each service provider, and the parent or adult student**