Adams Wells Special Services Cooperative
925 North Main Street – Bluffton, IN 46714
(260) 824-5880 ~ Fax (260) 824-8654

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

STUDENT: _____ DOB: _____

SCHOOL: _____ GRADE: _____ GENDER: ☐ Male ☐ Female

PARENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

☐ PERMISSION IS GRANTED

☐ PERMISSION IS NOT GRANTED

For the ADAMS WELLS SPECIAL SERVICES COOPERATIVE

TO RELEASE INFORMATION ☐ Verbally ☐ In Writing REGARDING THE ABOVE NAMED STUDENT TO: _____
(school official)

TO RECEIVE INFORMATION ☐ Verbally ☐ In Writing REGARDING THE ABOVE NAMED STUDENT FROM : _____
(school official)

_____
(school, agency, clinic, professional and/or organization to which disclosure is to be sent)

_____Phone:_____Fax:_____
(address, city, state, zip,)

THE SPECIFIC INFORMATION TO BE RELEASED/RECEIVED

☐ PSYCHOLOGICAL RECORDS	☐ PHYSICAL THERAPY/OCCUPATIONAL THERAPY
☐ IEP (goals and objectives)	☐ SPEECH/LANGUAGE THERAPY REPORTS
☐ PSYCHIATRIC RECORDS	☐ VISION/AUDIOLOGY REPORTS
☐ ORIGINAL REFERRAL FORM	☐ SUBSTANCE ABUSE*
☐ MEDICAL REPORTS	* student must sign if substance abuse information may be included in any reports requested.
☐ TREATMENT RECORDS	☐ OTHER

Requested by: _____

I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and my no longer be protected by the federal HIPAA Privacy Rule. I have been informed that I have access to and may review any or all of my child's school records and if so desire, to challenge the content of the records. All educational records are protected by the Federal Education Rights and Privacy Act (FERPA).

This release is valid for one year from date of permission. At any time I may revoke this release in writing.

_____ _____
(parent/guardian signature) (date)

_____ _____
(student signature) (date)

This authorization complies with HIPAA and Indiana Law.