Perkiomen Valley School District

3 Iron Bridge Drive
Collegeville, PA 19426

Authorization to Release/Furnish Information

I,_____, hereby authorize_____, of

_____to release information regarding my
Agency/School District

child,_____whose Date of Birth is _____
Name of Child *Date of Birth*

to_____or to communicate verbally with the aforementioned
Requesting Agency/School District

person or agency for the purpose of:_____
Reason for Request

The information, which may be released, includes:

- ☐ a. Individualized Education Program (IEP), Evaluation Report, NOREP
- ☐ b. Permissions, Psychological Testing/Evaluations
- ☐ c. Psychiatric Evaluations/Consultations (Protected Health Information PHI)
- ☐ d. Health/Medical Records- Protected Health Information (PHI)
- ☐ e. Academic Records/Progress Reports
- ☐ f. Achievement Test Results
- ☐ g. Health & Dental Records/Personal Health History
- ☐ h. Attendance/Discipline Records
- ☐ i. Unofficial Transcript

I understand that my authorization shall remain effective for a period of one (1) year from the date of my signature and that all information released will be handled confidentially. This authorization for release of confidential information is designed to meet the requirement for valid authorization under FERPA (34 CFR Part 99) and HIPAA privacy rules (45 CFR Parts 160, 164, and 164.508). I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written, dated communication. It is my understanding that I am not obligated to disclose any information if I do not wish to do so and I will permit a copy of the authorization to be used in lieu of the original. I, however, understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it. Furthermore, I understand that I am entitled to receive a copy of this authorization.

I certify that the meaning of the authorization has been explained to me, that I am signing this authorization voluntarily, understand that the receipt of treatment or educational programming is not contingent upon complying with this request for authorization, and that I agree to its terms.

X_____
Signature of Parent

_____
Signature of Student (NOT required for educational records: however, if over 14 may be required by mental health agencies)

X_____
Print Name of Parent *Date*

_____
District Contact *Position* *Phone* *Fax*