Cedar Rapids Community School District

RELEASE OF INFORMATION AUTHORIZATION rev. 10/21

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 authorization will not expire unless specified below.

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 the contact person listed above. I understand that the revocation will not apply to disclosure made prior to receiving the written notice. This authorization will not expire, 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. I understand that I have a right to inspect the information to be disclosed upon the proper notification and under conditions established by the source facility.

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** _____