# RECIPROCAL CONSENT TO RELEASE AND SHARE MEDICAL/EDUCATIONAL/OTHER IDENTIFIED INFORMATION

The Individuals with Disabilities Education Act (IDEA) requires Raleigh County Schools to obtain written consent prior to the exchange of any individually identifiable health information.

**STUDENT INFORMATION**

| NAME | | SCHOOL | |
|---|---|---|---|
| PARENT | | BIRTHDAY | |
| ADDRESS | | MEDICAID | |
| | | DIAGNOSIS | |
| TELEPHONE | | WVEIS | |

**PHYSICIAN, AGENCY, OTHER IDENTIFIED PERSON INVOLVED WITH THE STUDENT**

| NAME/TITLE | | | |
|---|---|---|---|
| ADDRESS | | | |
| TELEPHONE | | FAX | |

**SEND INFORMATION TO:** ______________________________
______________________________
______________________________
Telephone______________________
FAX__________________________

**ATTENTION OF:**
______________________
______________________

## CONSENT FOR RELEASE OF INFORMATION:

**Extent of information to be shared:** Information pertinent to the above individual's role in eligibility determination, assessment, Individual Education Plan (IEP) development and the provision of related services by Raleigh County Board of Education.

**Purpose for the request of information:** The information will be used to assist in the determination of an appropriate education program for the student. The authorization will permit Raleigh County Special Education professionals/school administrator and/or the physician/agency/other identified person involved with the student to freely exchange information regarding the student in order to provide the student services based on the educational needs determined by the Individual Education Plan (IEP).

**Method and persons with whom information may be shared:** Verbal and written correspondence between the identified physician/agency/other identified person involved with the student and the Director of Special Education, Designee of the Director of Special Education and School Administrator.

This information is for confidential use. All rights are protected under the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA) and the Individuals with Disabilities Improvement Act (IDEA). Consent may be revoked at any time upon the written request of the family or legal guardian, except to the extent that information has already been supplied under this authorization.

I give my informed consent for verbal and written communication between the identified physician/agency/other identified person involved with this student and the Director of Special Education/Designee and/or School Administrator.

___ **School Records:** Current grades, birth certificate, immunization record, achievement testing, attendance, report cards, discipline records, Eligibility Committee Report, current IEP, Classroom Teacher Reports(s), Classroom Observations(s), psychological evaluations, and other reports as needed such as speech/language, occupational therapy, physical therapy, social work, etc.

___ **Medical Records:** Medical, psychological records, brief summary of health history, diagnosis, current health status, and any other pertinent information deemed necessary to assist in implementing a safe and positive school experience for this student.

___ **Other (Specify)**______________________________________________

______________________________________________________________
Signature of Parent/Guardian/Surrogate Parent/Eligible Student Date

This consent will be valid for one year unless otherwise specified. This consent expires ______________________.