Pipestone Area Schools
1401 7th Ave SW
Pipestone, MN 56164
Phone: 507-825-5861
Fax: 507-825-6729

Authorization for Release of Information

1. Student Information

Name: _____ DOB: _____ Date: _____

School: _____ ID Number: _____

2. Parent/Guardian Information

Name: _____ Phone: _____

Address: _____ City: _____ State: _____

3. I am requesting:

District Name/No: _____

School: _____ Person: _____

Address: _____ City: _____ State: _____

☐ To release the specific information identified in Section 5 below to:

☐ To obtain the specific information identified in Section 5 below from:

4. Organization

Name: _____ Person: _____

Address: _____ City: _____ State: _____

5. Information to be released, created between ___/___/_____ and ___/___/_____:

☐ Special Education Records
☐ Teacher/Counselor/Staff Observations
☐ Social Work Report
☐ Psychological Report
☐ All Health/Medical Information

Or, release only the following specific portions of the student's health/medical information:

☐ History/Physical
☐ Medications
☐ Mental Health
☐ Discharge Summary
☐ Progress Notes
☐ Immunizations
☐ Other health/medical information: _____

☐ Other: _____

The following information requires special consent by law. Even if you indicate all health/medical information, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program
☐ Psychotherapy notes (this consent cannot be combined with any other)

6. Health Information includes written and oral information

By indicating any of the categories in Section 5, you are giving permission for written information to be released and for the person identified in Section 3 to talk to a person in Section 4 about your child's information.

If you do not want to give your permission for a person in Section 3 to talk to a person in Section 4 about your child's information, initial here: _____

7. Reasons for releasing information:

8. I understand that:

- By signing this form, I am requesting the information identified in Section 5 will be exchanged between the school and the organization identified in Section 4;
- I may stop this consent at any time by writing the district, school or person identified in Section 3;
- When the information specified in Section 5 is exchanged between the school and the third party identified in Section 4, the information could be redisclosed by the party that receives it and may no longer be protected by federal or state privacy laws;
- If the organization in Section 4 is a health care provider, they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent form; and
- This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:
  Date: ____/____/_____ or specific event: _____

9. Signature:

_____ _____

Parent/Guardian or Adult Student Date