



# Garfield Heights City Schools

5640 Briarcliff Drive / Garfield Heights, OH 44125 / 216.475.8100 Fax: 216.475.8296

## CONSENT FOR RELEASE OF INFORMATION PERSONAL & CONFIDENTIAL

\_\_\_\_\_  
Student/Parent/Guardian Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Grade Level

The following agency(s)/individual(s)/school district(s) have my permission to exchange/receive/share information regarding service delivery planning for the purpose of securing, coordinating, and/or providing services for the above named person (please identify all agencies/individuals/school districts that apply):

<u>Agency/Individual/School District</u>	<u>Phone# / Fax #</u>
Garfield Heights City Schools	216.475.8100 / 216.475.8296
_____ (School most recently attended)	_____ / _____
_____	_____ / _____
_____	_____ / _____
_____	_____ / _____

I authorize exchanging/giving/receiving/sharing/re-disclosing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the individual:  
(Circle yes or no and initial)

- | Circle one | Initial |  |
|------------|---------|--|
| Yes        | No      | _____ Identifying information: name, birth date, sex, race, address, and telephone number. |
| Yes        | No      | _____ Social Security Number   |
| Yes        | No      | _____ Case Information: the above identifying information plus:                            |

- Medical (EXCEPT for HIV, AIDS, and drug treatment records)
- Social History
- Treatment/service history psychological evaluations
- Individualized Education Plans (IEP)
- 504 Plans
- Individualized Family Service Plan (IFSP)
- Transition Plans
- Vocational Assessments
- Grades and attendance, including grades in progress
- School profile explaining credits and grading system
- Standardized test scores (achievement/ability, competency, etc.)
- Proficiency Test scores
- Immunization/health records
- Speech/hearing/language evaluation
- Other information regarding me or the individual named above (disability, type of services being received and of agency providing services to me or the individual named above)

Name \_\_\_\_\_

**Information regarding the following shall not be released unless initialed below:**

Yes No \_\_\_\_\_ Other: \_\_\_\_\_

Yes No \_\_\_\_\_ HIV and AIDS related diagnosis and treatment

Yes No \_\_\_\_\_ Substance abuse diagnosis, treatment, treatment progress, and drug screen results.

Yes No \_\_\_\_\_ **Financial Information:** Public assistance eligibility and payment information provided for establishing eligibility including but not limited to pay stubs, W2s and tax returns, and other financial information.

I understand that the Consent for Release of Information expires 180 days from the date it is signed unless otherwise indicated herein by me. I also understand that I may cancel this Consent for Release of Information at any time by stating so in writing with the date and my signature and delivering it to **Garfield Heights City Schools**. The revocation does not include any information, which has been shared between the time that I gave permission to share information and the time that it was canceled.

I understand that my signing or refusing to sign this consent will not affect public benefits or services that I am eligible for.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Person/Student

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent/Guardian (if student under 18)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Witness/Agency Representative

***Violation of Federal Law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.***

**TO ALL AGENCIES RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:**

1. If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

Information disclosed pursuant to this consent has been disclosed to you from records whose confidentiality is protected by Federal Law.

Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

2. If the records released include information of an HIV-related diagnosis or test results the following statement applies:

This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to who it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is **NOT** sufficient for the purpose of the release of HIV test results or diagnoses.

3. The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the further disclosure is expressly permitted by the person to whom it pertains, Juvenile Court/DYS in the case of Youth records, or applicable federal and/or state law.

original – GHCS      copy – Agency/School District      copy – Student/Family