



**VanderBerge  
Middle School**  
948 Proctor Avenue  
Elk River, MN 55330  
Office: 763.241.3450  
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www.isd728.org/vms

CONSENT  
TO RELEASE  
PRIVATE DATA

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

*This form allows information about your child to be exchanged. Please sign and return it.*

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Address \_\_\_\_\_

I hereby authorize Independent School District 728, the Elk River Public Schools, and its staff, as follows:

<input type="checkbox"/>	to release information to:	(Check either or both boxes, as needed)
<input type="checkbox"/>	to obtain information from:	

Name, Title \_\_\_\_\_ Organization \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

School records may be examined by guardian(s), or student if age 18 or older. The information to be released:

- |   |   |
|---|---|
| <input type="checkbox"/> All School records and educational data            | <input type="checkbox"/> Teacher/Counselor/Staff Observations       |
| <input type="checkbox"/> All health records and related data                | <input type="checkbox"/> Chemical Abuse/Dependency data             |
| <input type="checkbox"/> Psychological reports and related data             | <input type="checkbox"/> Medical Report (including related service) |
| <input type="checkbox"/> Special education and all related records and data | <input type="checkbox"/> Psychiatric Report                         |
| <input type="checkbox"/> Other (please specify) _____                       | <input type="checkbox"/> Social Work report                         |

The purpose for this request: \_\_\_\_\_

I understand that this authorization takes effect the day I sign it. It expires on \_\_\_\_\_ or no more than one year from the date of my signature, whichever is earlier.

I also understand that I may revoke this authorization at any time by providing a signed, written notice of revocation to Elk River Public Schools. A photocopy or facsimile of this Authorization has the same legal effect as the original.

In the case of protected health or medical information, I hereby authorize the healthcare provider to discuss, disclose, and otherwise release any and all medical records, medical data, and health data identified above to the Elk River Public Schools and its staff and representatives pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations, 45 C.F.R. § 164.508. I understand that the healthcare provider may not condition treatment or payment on whether I execute this authorization. Health or medical information that is disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by the privacy regulations promulgated pursuant to HIPAA. Records that are received by the School District may be protected from re-disclosure under the Family Education Rights Privacy Act and the Minnesota Government Data Practices Act.

Parent Signature \_\_\_\_\_