Ridgway Area School District

WRITTEN AUTHROIZATION TO REQUEST / RELEASE STUDENT RECORDS TO AN AGENCY

What is the Purpose of This Form?

This form is used to obtain parental permission to request records or release records to another agency other than a school district. Examples of agencies are: Beacon Light Behavioral Health Systems, Dickinson Mental Health Center, Doctor's Offices, Hospitals, etc.

Who Should File This Form?

Administrators and guidance counselors should use this form when they become aware of services that a student is receiving or has received from another agency.

When Should this Form be Filed?

Immediately upon knowledge of other service providers in order for the district to better understand the student and his/ her needs. This form should also be completed if the parent / student requests his/her school records be sent to another agency.

Special Notes:

This forms need to be kept on file. They should be placed in the Category B file – not in the student's Category A file (Permanent Record).

Revised: July 2003

Clear Data From Form

RASD **RIDGWAY AREA SCHOOL DISTRICT** RASD
P. O. BOX 447
RIDGWAY, PA 15853

***IMPORTANT*: *Send information to the attention of the office selected below using the above mailing address*:**

☐ **ELEMENTARY OFFICE**
TEL: 814/776-2176
FAX: 814/776-4247

☐ **MIDDLE SCHOOL OFFICE**
TEL: 814/776-4200
FAX: 814/776-4239

☐ **HIGH SCHOOL OFFICE**
TEL: 814/773-3164
FAX: 814/773-3115

☐ **OFFICE OF STUDENT SERVICES**
TEL: 814/776-4255
FAX: 814/776-4298

WRITTEN AUTHORIZATION TO REQUEST / RELEASE STUDENT RECORDS

TO: _____ **DATE OF REQUEST:** _____

_____

_____

RE: _____ **STUDENT DOB:** _____

Request / Release to an Agency

The following information is requested / released in order to: _____

- ☐ Psychiatric Reports (May include PHI*)
- ☐ Psychological Reports (May include PHI*)
- ☐ Medical Treatment / History (May include PHI*)
- ☐ Social Casework Reports (May include PHI*)
- ☐ Counseling / Therapy Records (May include PHI*)
- ☐ Intake Data & Social History (May include PHI*)
- ☐ Individual Service/Treatment Plan (May include PHI*)
- ☐ Other: _____
- ☐ Progress Notes (May include PHI*)
- ☐ Academic Records
- ☐ Special Education Records (May include PHI*)
- ☐ Probation (May include PHI*)
- ☐ Discharge Summary (May include PHI*)
- ☐ Recommendations (May include PHI*)
- ☐ Exchange of Verbal Information (May include PHI*)

***PHI – Protected Health Information**

I/We understand the following:

- The designated information will be exchanged with the understanding that absolute confidentiality will be maintained.
- Photocopies of this authorization shall be considered valid.
- This written authorization shall expire one year from the date signed.
- This written authorization may be revoked at any time by notifying, in writing, the Privacy Officer in the Office of Student Services at the above address.
- The identified agency and its staff/employees have no responsibility or liability as a result of any re-disclosure.
- I/We am entitled to a copy of this Written Authorization form.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE OF SIGNATURE

_____ _____
SIGNATURE OF STUDENT* DATE OF SIGNATURE
**If s/he is age fourteen (14) or will be age fourteen (14) during the duration of this release.*

Thank you for your assistance and timely attention to this request. Please send records to the attention of _____ at the office specified above.