

Sunrise River Elementary School  
37775 Grand Avenue  
North Branch, MN 55056

**CONSENT TO RELEASE  
PRIVATE DATA**

**Parent/Guardian(s): This form allows information about your child to be exchanged. Please sign and return it to the school.**

Student's Full Name:

Birth date:

Grade:

School:

Parent/Guardian Phone Number:

Parent/Guardian Name(s):

Parent/Guardian Address:

School District name and person responsible  
I authorize :

Fax:

651-674-1110

Phone: 651-674-1100

Address

37775 Grand Avenue

City

North Branch,

State and Zip

MN 55056

To release information to:

To obtain information from (Check either or both boxes, as needed)

Name and Title

Organization

Address

City

State and Zip

Phone Number

Fax Number

Telephone Number

Purpose for request:

Official School Records (name, address, date of birth, sex, attendance record, grade level, grades, class rank, standardized group test results)

Health Records

Chemical Health Reports

Psychological/Mental Health reports

Medical Report (including related services)

Special Education Records (including related services)

Psychiatric/Mental Health Reports

Teacher, Counselor, Staff Observations

Human Service Reports

Phone Consultations

Others (specify)

This authorization releases records prior to and following signature date. All records received will become part of the student's educational records. These records will be used to coordinate health and educational needs and will be maintained and transferred in accordance with School District policies and procedures. Unless otherwise specified in this release, if records are authorized to be mutually exchanged between the School District and the agency or individual listed, I understand that the records I authorize to be released may be exchanged at any time only between the School District and this agency or individual during the term of this authorization. I understand that upon release, this health information may no longer be protected by federal health care privacy rules. However, other state and federal laws governing the disclosure of educational data may prohibit the redisclosure of such information without first obtaining an additional authorization. I also understand that I may revoke or change this authorization, in writing, at any time, by sending a letter to the School District, which reflects my wishes in this regard. I also understand that I may revoke the authorization in accordance with the instructions contained in [name of person or agency providing health information]'s notice of privacy practices. **[Name of person or agency providing or holding health information] may not withhold treatment, payment, enrollment, or eligibility for benefits if I do not sign this authorization.**

This authorization expires on \_\_\_\_\_ or no more than one year from the date of my signature.

Parent/Guardian Signature (or Student if of legal age)

Date: