North Branch Area Schools, District #138 38431 Lincoln Trail 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:		
	Birthdate:	Grade:	School:
	Parent/Guardian Phone Number:		

Parent/Guardian Name(s)	
Parent/Guardian Address	
(School District name and person responsible) I authorize **North Branch Middle School**	FAX: **651-674-1310** Phone: **651-674-1309**
Address: **38431 Lincoln Trail**	City, **North Branch, MN 55056** State, Zip Code:

To release information to:	X To obtain information from:	*(Check either or both, as needed)*

Name and Title		
Organization		
Address	City State and Zip	
Phone Number	FAX Number	Other Phone Number
Purpose for request		

Revised August 27, 2003

	Official School Records (name, address, date of birth, gender, attendance record, grade level, grades, class rank, standardized group test results)		
X	Health Records		Chemical Health Reports
	Psychological/Mental Health reports	X	Medical Report (including related services)
	Special Education Records (including related services)		Psychiatric/Mental Health Reports
	Teacher, Counselor, Staff Observations		Human Service Reports
X	Phone Consultations	X	Others (specify) Anything information pertinent to education

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