



The District School Board of Collier County
 Information Exchange Authorization - Educational / Medical / Health

Sec I. Student Information

Student Name: _____ Date of Birth: _____
 Student ID: _____ Grade: _____ Teacher: _____

Sec II. School Information

School Name: Collier County Public Schools/ _____ Phone: _____
 School Address: _____ City: _____ State _____ Zip _____
 School Contact: _____ Title: _____
 Email: _____ Fax: _____

Sec. III Provider/Agency to Receive or Release Information

Name of Provider/Agency: _____
 Address: _____ City: _____ State _____ Zip _____
 Profession: _____
 Phone: _____ Ext: _____ Fax: _____
 Email: _____

Sec. IV Information to be Exchanged Indicates whether to Receive and/or Release

	<i>Information to exchange</i>	<i>Receive</i>	<i>Release</i>		<i>Information to exchange</i>	<i>Receive</i>	<i>Release</i>
	Academic Records				Physical Therapy Evaluations		
	EP -Education Plan (Gifted)				Positive Behavior Intervention Plan		
	Functional Behavior Assessment				Psychological Reports		
	IEP-Individual Education Plan (ESE)				Section 504 Records		
	IHP-Individual Health Plan				Standardized Test Scores		
	Immunization Records				Speech Language Evaluations		
	Occupational Therapy Report				Teacher Ratings/Observations		
	Verbal Communication				Official School Transcript		
	Medical/Health*Specified below						

Other *Specify _____

Sec V. Purpose for this request:

- Educational Planning
 For provision of health-related services
 Other - Specify _____

Sec. VI Parent/Guardian Information & Consent

Parent/Guardian Name: _____ Relationship: _____
 Cell Phone: _____ Phone (other): _____

I, _____, authorize Collier County Public Schools to exchange my child's educational, health, and/or medical Information as designated in Sec (IV). I am aware that the information will be held in strict confidence and will be used to evaluate and plan for my child's educational, medical, and/or health services and interventions. I also understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my revocation to the Provider/Agency from which the information was being requested from. I understand that the revocation will not apply to the information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization to release any educational/medical information will be ongoing from the following dates from _____ till _____ (expiration date).**

 Signature of Patient/Parent/Guardian

 Date

Information security and confidentiality are matters of serious concern for all persons who have access to student education, health, and medical records. The information contained in a student 's "educational records " is protected by the Family Educational Rights and Privacy Act (FERPA of 1974(20U.S C. 123g(a)). The Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule (Code of Federal Regulations, Title 45, Part 164) governs how "covered entities " may use and disclose "protected health information ". The Federal Family Rights and Privacy Act does not require parent permission for sending records to a school to which a student is transferring. In such case no parent authorization may appear here.