COUNCIL BLUFFS COMMUNITY SCHOOL DISTRICT
REQUEST TO RELEASE RECORDS/INFORMATION
Medical/Psychological Diagnosis/Information

Release to: _____

Release From: _____

This will authorize: _____
(Name of physician/clinic)

_____
(Address: Street/City/State/Zip)

to release all information including, but not limited to, psychological, emotional, social, medical, diagnosis and other available reports and/or evaluations for me or my child for the use in individual educational planning (IEP) to:

_____
(Name of School or Agency)

_____
(Address: Street/City/State/Zip)

Student Name: _____

Date of Birth: _____

Diagnosis: _____

Physician Signature: _____

Date: _____

Parent Signature: _____

Date: _____

HIPAA guidelines

The purpose of the release is to obtain medical records that would be HIPAA compliant in the release of information. The components would include plain language, specific information i.e. diagnosis, specificity in disclosure of information through releasing and receiving of information, signature and date. It will become a part of this student's cumulative school record and will be subject to the privacy requirements of the family education rights and privacy act (FERPA). A full explanation of FERPA is included in the school handbook that was provided to you at time of registration. Information will be specifically used for Individual Educational Planning (IEP) for this student.