MINNEAPOLIS PUBLIC SCHOOLS
Urban Education. Global Citizens.

PRIVATE MEDICAL/HEALTH DATA CONSENT TO RELEASE/REQUEST

Parent(s), this form allows information about your child to be exchanged. Please sign and return it to the school.

Learner's Full Name: _____ Grade _____

ID: ☐☐☐☐ ☐☐☐☐☐ ☐☐☐☐☐ Birthdate: ☐☐ ☐☐ ☐☐☐☐ Today's Date: ____/_____/_____(M/D/Y)

Parent Name: _____ Parent Address: _____

I authorize ____***The School Nurse at my student's school***_____for Special School District No.1 at:
(Person responsible/Position)

_____Minneapolis, MN_____
Address Zipcode

☐ to release written and verbal information to:
☐ to obtain written and verbal information from:
(*Check either or both boxes as needed*)

Name, Title _____***School Based Clinic Staff***_____

*Organization*_____

_____
Address *City* *State* *Zip code*

The information to be released:

☐ Social Work Report ☐ Psychiatric Report ☐ Psychological Report
■ Medical Reports [immunizations, audiological and vision testing, recent physical exam, allergies, admission and discharge summaries, acute and chronic health problems] ***needed to complete Sports Physical***
☐ Chemical Abuse/Dependency Report (Student consent or separate court order needed)
■ Others (specify) ____***School Health Record Information***_____
☐ Others (specify) _____

The purpose for the request is:

- To determine health needs of your child that may require attention during school.
- To provide school personnel with a better understanding of your child's health needs.
- To facilitate evaluation of your child's individual educational program.

1) I understand that this consent takes effect the day that I sign it. It expires on _____(M/D/Y) or no more than one year from the date of my signature.
2) I may revoke or change this consent at any time by sending a written notice of the revocation or change to the releasing school.
3) My or my child's eligibility for services may not be conditioned on the signing of this authorization.
4) Once the requested information is released from the HIPAA-covered entity, the information may no longer be protected by HIPAA, though information considered educational records under FERPA will be protected accordingly.

***** _____ Month/Day/Year: _____
Parent/Guardian Signature (or Learner, if of legal age or to release chemical abuse/dependency treatment report)

- MPS may re-release information to any outside agencies if required or authorized by law.
- A photocopy of this completed form is valid as original

- MPS is not authorized or funded to pay for this information