

# Authorization for Release of Records

Lake Geneva School District

Student Name:

Date of Birth:

**INSTRUCTIONS:** Complete one or both of the Authorization Statements below, place checkmarks by the information that may be disclosed and sign the authorization. In order to allow the exchange of information between the Lake Geneva School District(s) and the identified individual/entity, please check both of the Authorization Statements.

## AUTHORIZATION STATEMENTS:

I, the undersigned, hereby authorize the Lake Geneva School District(s) and/or \_\_\_\_\_ to disclose by any means (including written, oral or electronic means) the information indicated below regarding the student to:

Name: Lakes Area LifeWay - The Sunshine Project

Address: N2440 Ara Glen Drive, Lake Geneva, WI 53147

Phone: 262-581-6999 Fax: \_\_\_\_\_

I, the undersigned, hereby authorize \_\_\_\_\_ (Insert name of school, individual, organization, or agency) to disclose by any means (including written, oral or electronic means) the information indicated below to the Lake Geneva School District(s) and/or \_\_\_\_\_.

## INFORMATION TO BE DISCLOSED:

- Education Information / Records
- Progress Records
- Behavioral Records
- Student Physical Health Records
- Psychological Records
- Special Education Records
- Outside Agency Records
- Law Enforcement Records

- Health Information Records
- Patient Health Information  
(Specify or indicate "all")

- Alcohol/Drug Abuse Records

- Mental Health Records
- Developmental Disabilities
- HIV (AIDS) Records
- Other Information/ Records**
- Other (specify)

**PURPOSE OF DISCLOSURE:** The information is requested for the purpose of educational programming and service, medical evaluation and treatment, health assessment and planning, or other (specify, such as "at request of the individual"):

DATE: \_\_\_\_\_

**ACKNOWLEDGEMENTS:** Receive Records & Authorization - I understand that I have a right to a copy of the records that are disclosed and a right to a copy of this authorization. Withdrawal of Authorization - I understand that I have the right to revoke this authorization, except to the extent that disclosure has already been made in reliance on this authorization. I understand that my revocation is effective only if it is in writing and it is submitted to the individual/entity that is releasing information. Re-Disclosure of Health Information - I understand that if my child's health information is released pursuant to this authorization, it may be subject to re-disclosure by a person who receives the health information and may not be protected by federal law. Voluntary Authorization - I understand that a health care provider may not condition health care treatment, payment or eligibility for health plan benefits on whether or not I sign this authorization.

This permission is valid for one year from the date signed. A copy of this form is as effective as the original. I certify that I am the parent, legal guardian, personal representative of the above named student, or that I am the student of majority age, and have authority to sign this release.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Student

(Parent, foster parent, guardian, school official, or adult student)

Please return this form to:

Lake Geneva Schools – Student Services

Attn: Joe Reynolds

208 South Street

Lake Geneva WI 53147

Phone: 262-348- 1000 ext 1102

Fax: 262-248-6609