Mosinee School District
"Expect the Best"

REQUEST / CONSENT FOR RELEASE OF PUPIL RECORDS

Purpose of Disclosure:

Information will be used to aid in appropriate educational planning

Other: _____

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

Parent Name: _____

I hereby request and authorize:

☐ Mosinee High School
1000 High Street
Mosinee, WI 54455

☐ Mosinee Middle School
700 High Street
Mosinee, WI 54455

☐ Mosinee Elementary School
600 12th Street
Mosinee, WI 54455

Attn: _____ Attn: _____ Attn: _____

☐ to receive from

Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

☐ Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement results)

☐ Psychological evaluations or social work reports

☐ Medical and/or related health records

☐ Appropriate agency reports

☐ Individualized education plan

☐ Others: (specify) _____

The authorization is effective for 120 days from the date of signing or as specified by the condition stated:

(no longer than one year) _____

RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION: You have the right to receive a copy of this authorization

REDISCLOSURE NOTICE: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, the health information disclosed as a result of this authorization may no longer be protected by the Federal Privacy Standards, if such person(s) and/or organization(s) redisclose my health information

RIGHT TO WITHDRAW THIS AUTHORIZATION: I understand that if I want to cancel this authorization, I must do so in writing. To obtain a form to cancel this authorization, I may contact the Health Information Management (medical records) department. I understand that my cancellation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have made prior to the receipt of my cancellation form. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself

RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: research related treatment • health plan enrollment or eligibility • the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party

Signature of Parent/Legal Guardian/Adult Student: _____ Date: _____

Relationship to Student: _____

This information has been disclosed to you from records protected by Federal confidentiality rules (41 CRF Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information in NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

It is understood that parent/legal guardians may have access to inspect their contents (WI Law Chapter 254 and Federal Law Title V., Sec 438) Parents may revoke this at any time