Seward School District
Seward, Nebraska
AUTHORIZATION FOR RELEASE OF RECORDS/INFORMATION

Student: _____ Birthday: _____ Grade: _____

School: _____ Student No: _____

PURPOSE OF AUTHORIZATION FOR THE RELEASE OF RECORDS: As a parent or guardian you have the right to give permission or not give permission for the exchange of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Federal Family Education Rights and Privacy Act (for example, transfer of records from one school district to another).

I hereby authorize the mutual exchange of confidential information and the release of records among and between the Seward School District and the person(s) or agency listed below:

To/From: _____
(Name of agency/person)

_____
Street Address

_____
City, State, Zip

_____
Phone number/FAX number

From/To: _____
(District employee/title and school or department)

_____
Street Address

_____
City, State, Zip

_____
Phone number/FAX number

Check all record types to be released:

☐ Health/Medical Records/Athletic Physical
☐ Attendance Data
☐ Achievement/Aptitude/Interest Test Scores
☐ Psychological/Counseling Records
☐ Transcripts
☐ Special Education Records
☐ Other (specify): _____

The reason for disclosing the record(s) is: _____

I understand that the information obtained by the Seward School District will be treated in a confidential manner under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information the medical information received by the District is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

Note: For release of medical records, the authorization will automatically expire 90 days from the date of signing.

I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

_____
Parent/guardian signature/Student (if 18)

_____
Date

_____
Street address

_____
City, State, Zip

1/05