REPLACEMENT FORM

Form 8330 F4

Traverse City Area Public Schools
412 Webster Street, Traverse City, MI 49686
231-933-1700
Fax: 231-933-1721

CONSENT TO RELEASE, OBTAIN, OR EXCHANGE STUDENT INFORMATION

General Information

Date of Request: _____ Expiration (one year from signature): _____ Dates range of records requested: _____

Student Name (last, first, middle): _____ DOB: _____

Reason for Request and Means of Communication

The reason for this request is to aid in present and future educational planning and decisions.

Circle one: TCAPS to release records, TCAPS to obtain records, TCAPS & Agency to exchange information (two way, reciprocal)

Requesting Agent

TCAPS School:_____ Phone: _____ Fax: _____

Certified Staff Member: _____ Position: _____

Named Agent

Agency/Organization:_____ Phone: _____ Fax: _____

Contact Person: _____ Position: _____

Information Requested

TCAPS Records (to release)	Agency Records (to obtain)	Two way, reciprocal exchange of Info.
Special education report/IEP	Psychiatric evaluation	Anecdotal (teacher, social worker, principal)
Report card	Psychological evaluation	Anecdotal (therapist, psychologist, doctor)
TASC/Child Study notes	Treatment summary/therapy notes	Exchange of all information (verbal)
Social work assessments	Medical information/med review	Exchange of all information (written)
Other: _____	Other: _____	Other: _____

Acknowledgment and Authorization

It is my understanding that the release information will be used in the educational planning for the above named person. I hereby authorize the above named source to release or disclose to Traverse City Area Public Schools to the individual listed above the information specified above for the student listed above. This may include 1) All medical records or other information regarding the treatment and/or out patient care for the following conditions, including psychological, medical, and physical. 2) Information about how the disability affects ability to complete tasks and activities of daily living in and around the school setting, including but not limited to classroom, gymnasium, and playground. I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information may include treatment of psychiatric, substance abuse, and HIV/AIDS related illness. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. However, re-disclosure of this information is prohibited by the Michigan Mental Health Code (sections 748, 749 and 750 of the Public Act 258 of 1974 as amended) and also by Title 42 of the Code of Federal Regulations Part II with which this authorization complies. The released information may not be copied, shared or re-released except as consistent with the authorized purpose above. I understand that I am not required to sign this authorization. I have a right to inspect and obtain a copy of the information disclosed. I authorize the use of fax, photocopy and e-mail of this form for the release or disclosure of the information described on this form. I understand this authorization, except for action already taken, may be voided by me at any time. Notification to revoke consent must be in writing. If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature or upon the following date, event or condition:

_____.

I have had the opportunity to have this form explained to me and have my questions answered. I have been offered a copy of this form and I agree to the stated request.

Signature of parent/guardian/student (if over 18): _____ Date: _____

Signature of witness: _____ Date: _____

REPLACED 4-14-14