PURPOSE: As a parent, guardian or student, you have the right to give permission or not give permission for the release 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 until release of records is allowed under one of the exceptions under the rules implementing the Family Education Rights and Privacy Act, FERPA, (for example, transfer of records from one school district to another).

Licking Valley Local School District

1379 Licking Valley Road Newark, OH 43055 Tel. 740.763.3525
Superintendent: Scott Beery
Director of Student Services: Tiffany Schmitz
District Nurse: Jamie Eberts
www.lickingvalley.k12.oh.us

Authorization for Release of Information School Year ______________

All matters relating to the physical or mental condition of children are considered privileged and confidential and are treated as such by the staff of the Licking Valley Local Schools. Information regarding such matters cannot be given without consent of the parent of an individual under the age of 18. If over 18, the individual's consent is needed. In some cases, written consent must be obtained from the guardian, if there is a guardian. Licking Valley Schools is hereby granted my permission to exchange/release any pertinent information that may be necessary regarding the educational/medical assessments/records/reports and program of placement of:

Student Name: ____ Student DOB (mm/dd/yyyy):____________________

Please check designated agencies/ individuals to exchange information:

	Please Name Specific Information (names, organizations, etc.):
___L.C. Board of Developmental Disabilities	____
___Licking County Mental Health	____
___Opportunities for Ohioans with Disabilities	____
___School District	____
___Children's Services Board	____
___Licking County Health Department	____
___Licking County Job and Family Services	____
___Department of Youth Services	____
___Hospital (**please specify**)	____
___Physician (**please specify)**	____
___Psychologist	____
___Service Provider Agency	____
___Social Security Administration	____
___Other	____

I understand that this information obtained will be treated confidentially by Licking Valley Schools 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 (HIPPA).

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

Signature of person authorized to consent: ____Date: ____________
Relationship to student: _______________________________________Phone/Cell: ___________________________
Address: ____

*Consent will be valid for one year unless the authorizing individual requests that consent be revoked at any time.

Note: For the release of medical information, the authorization can be no longer than 90 days after this authorization is signed.