AUTHORIZATION TO RELEASE INFORMATION
ELYRIA CITY SCHOOL DISTRICT

Section I: **Student Information**

This form provides authorization to release information relating to the personal health or educational information of the following student:

NAME: ____ DATE OF BIRTH: ________________

ADDRESS: ____ PHONE: ______________________

Section II: **Disclosure and Use of Personal Health or Educational Information**

____I hereby give my permission to ____ (name of provider) to use and disclose my personal health information in the manner described below.

____I hereby give my permission to Elyria City School District to release information to _______________________________________ to use and disclose my information in the manner described below.

Section III: **Description of Personal Health or Educational Information to be Disclosed**

Describe the personal health or educational information you are authorizing to be disclosed (for example: all medical records related to treatment for ADHD or all medical records relating to treatment for depression, ETR, IEP, etc.):

____
____

Section IV: **Description of Persons or Entity Authorized to Receive and Use Personal Health Or Educational Information:**

Authorized representatives at *Elyria City School District*, which is located in *Elyria, Ohio* with the phone number of (*440) 284-8258* have my permission to receive and use the above referenced personal health and educational information.

Section V: **Purpose of this Authorization**

The purpose of this disclosure of personal health or educational information:

____ To aid in making present and future educational decisions
____ Other: ____

Section VI: **Expiration and Revocation**

This authorization may be revoked (cancelled) at any time except to the extent that the provider has already released personal health or educational information to the recipient in reliance on this authorization. **Requests for revocation must be in writing** with your signature and date and delivered to the *Special Education Director of the Elyria City School District* which is located in *Elyria, Ohio* and whose phone number is *(440) 284-8258*. If this authorization is not revoked, **it will expire one year after the date in which the authorization is signed.**

Section VII: **Signature or Refusal to Sign this Authorization**

I understand that my signing or refusing to sign will not affect public benefits or services that I am eligible for.
Signature: ____Date: ____________

If a representative (for example: spouse, parent, legal guardian, durable power of attorney for health care, etc.) signs this form on behalf of the individual, please complete the following:
Representative's Name: ____
Representative's Relationship: ____
Date: ____