

Pine Island Public Schools
CONSENT TO RELEASE PRIVATE DATA

Parent(s), this form allows information about your child to be exchanged. Please sign and return to the school.
(address below)

Learner's Full Name: _____

ID _____ Birthdate _____

Month/Day/Year _____

School: _____ Grade: _____

Parent Name: _____ Parent Address: _____

I authorize Pine Island Public Schools District # 255

School district name and person responsible
223 1st Ave SE

Address

Pine Island

MN

55963

City

State

Zipcode

- to release information to: *(check either or both boxes, as needed)*
 to obtain information from:

Hannah Frost, MSW, LGSW

Name, Title

Zumbro Valley Health Center

Organization

343 Woodlake Dr. SE

Address

Rochester

MN

55904

City

State

Zipcode

School records may be examined by parent(s), or learner if of legal age. *The information to be released:*

Official School Records (*name, address, birthdate, sex, attendance record, grade level, grades, class rank, standardized group test results*)

Health Record

Chemical Abuse/Dependency Report

Psychological Reports

Medical Report (including related services)

Special Education Records (including related services)

Psychiatric Report

Teacher, Counselor, Staff Observations

Social Work Report

Others (specify) _____

Others (specify) _____

The purpose for the request: Care Coordination and ongoing treatment

I understand that this authorization takes effect the day that I sign it. It expires on _____ (Month, Day, Year) or no more than one year from the date of my signature. I also understand that I may change this authorization at any time.

Month/Day/Year _____

Parent Signature (or Learner, if of legal age)