



Mounds View Public Schools
350 W. Hwy 96
Shoreview, MN 55126

**CONSENT
 TO RELEASE
 PRIVATE DATA**

Section I

Student's Name: _____ ID#: _____ Date: _____
 School: _____ Grade: _____ Date of Birth: _____

Section II

Name: _____ authorizes District: **Mounds View Public Schools (#0621)**

- to release the specific information identified below *to*:
 to obtain the specific information identified below *from*:

Name of individual or entity: _____

Address: _____

Section III

- | | |
|---|---------------------------------|
| <input type="checkbox"/> Health Records | Created between _____ and _____ |
| <input type="checkbox"/> Medical Reports | Created between _____ and _____ |
| <input type="checkbox"/> Chemical Abuse/ Dependency Reports | Created between _____ and _____ |
| <input type="checkbox"/> Psychological Reports | Created between _____ and _____ |
| <input type="checkbox"/> Psychiatric Reports | Created between _____ and _____ |
| <input type="checkbox"/> Teacher, Counselor, Staff Observations | Created between _____ and _____ |
| <input type="checkbox"/> Special Education Records | Created between _____ and _____ |
| <input type="checkbox"/> Social Work Report | Created between _____ and _____ |
| <input type="checkbox"/> Other (specify) | Created between _____ and _____ |

For the purpose of:

Section IV

I understand this authorization

- takes effect the day I sign it
- cannot exceed one year, and expires either
 - on ___/___/___ (mm/dd/yyyy), or
 - one year from the date of my signature

• can be stopped any time by sending a written request to

Return this form to the name/address shown above

Signature: _____

Date: _____

Protected health information used or disclosed pursuant to the authorization may or may not be subject to re-disclosure by the recipient