DATE SENT/MAILED _____

Leander Independent School District
306 W. South Street
Leander, TX 78641 - (512) 570-0300

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Student Name: _____ ID#: _____ Date of Birth: _____

_____

Contact 1: _ MEDICAID# _____

This consent for disclosure of confidential information is for release of the student's confidential information between Leander Independent School District and a third party, as follows:

_____ _____
NAME OF PERSON NAME OF AGENCY

ADDRESS: _____
ADDRESS: _____
ADDRESS: _____
PHONE #: _____
FAX/EMAIL: _____

RECORDS REQUESTED/RECORDS TO BE RELEASED:	PURPOSE OF DISCLOSURE
☐ FIE, ARD, IEP, State Assessment Results ☐ Psychological Evaluations ☐ Transition Data/Vocational Testing ☐ Medical records If the person or entity that receives the information is not a healthcare provider or health plan covered by federal policy regulations, the information may be re-disclosed and no longer protected by federal privacy laws or regulations ☐ Other:	☐ To assist outside person/agency in providing non-educational support ☐ To assist ARD committee in educational planning ☐ Parent request ☐ Other:

For more information, please call:

_, _____ at _____
SCHOOL STAFF PERSON, POSITION TELEPHONE NUMBER

DATE SENT/MAILED _____

Leander Independent School District
306 W. South Street
Leander, TX 78641 - (512) 570-0300

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Student Name: _____ ID#: _____ Date of Birth: _____

Contact 1: _ MEDICAID# _____

Please respond to each statement with a **YES** or **NO** and sign at the bottom. If you indicate **YES** in response to all of the statements below and sign at the bottom, you will be giving your consent for disclosure of your/your child's confidential information.

☐ Yes ☐ No I have been fully informed in my native language or other mode of communication and understand the school's request for my consent, as described above. This information will be disclosed/requested upon receipt of my written consent.

☐ Yes ☐ No I understand that my consent for the disclosure of confidential information is voluntary and may be revoked at any time by contacting my local school district/charter school. However, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

☐ Yes ☐ No I give my consent for the disclosure of confidential information. Unless otherwise revoked, this authorization will expire 180 days from the date of this authorization.

_____ _____
NAME OF PARENT, GUARDIAN, SURROGATE PARENT, OR ADULT STUDENT DATE

_____ _____
SIGNATURE OF PARENT, GUARDIAN, SURROGATE PARENT, OR ADULT STUDENT DATE

_____ _____
NAME OF INTERPRETER, IF USED DATE

_____ _____
SIGNATURE OF INTERPRETER, IF USED DATE

Please return this form to:

, _____ at _____ as soon as possible.
SCHOOL STAFF PERSON, POSITION SCHOOL