Livingston EDUCATIONAL SERVICE Agency

PERMISSION TO EXCHANGE INFORMATION

Student Name _____ Birth Date _____

Present Address _____
Street *City* *Zip Code*

Former Address _____
Street *City* *Zip Code*

I hereby authorize the following persons and/or agencies to engage in verbal or written communication concerning the person named above. All pertinent records and information can be exchanged between agencies. All information will be used to make program or service decisions for the person named above. All information will be given the confidential treatment required by law and regulations. I am aware that I may deny or modify consent for disclosure between agencies.

The agencies authorized to exchange information include:

- ☐ Livingston Educational Service Agency
- ☐ Livingston County Family Independence Agency
- ☐ Livingston County Health Department
- ☐ Livingston County Community Mental Health Services
- ☐ Head Start
- ☐ Hospital _____ *(Name)*
- ☐ Other: _____
- ☐ Other _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

The following records may be exchanged:

- ☐ Evaluations based on psychological testing
- ☐ Social/developmental history
- ☐ Health/medical records
- ☐ Speech & Language reports
- ☐ OT/PT reports
- ☐ Vision/hearing reports
- ☐ Staffing reports
- ☐ IEPs
- ☐ Progress reports
- ☐ Other: _____

Information will NOT be disclosed to any other party without prior written consent of the parent or legal guardian except to another school district in which the student seeks to enroll. This authorization shall continue in effect until revoked in writing or not longer than one year.

Signature of Parent/Guardian	Relationship	Date
Signature of Witness	Name of Witness	Date

Note: This release does ***not*** include substance abuse information subject to federal confidentiality regulations, 42 CFR Part 2, or information about serious communicable diseases (HIV, AIDS, ARC, TB, Hepatitis). ***A separate release form is required to obtain this information.***