SAU #89 - Mason School District
(603) 878-2962 Fax (603) 878-3439

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

Date:			
To/From:		To/From:	Main Office
Address:		Address:	Mason School District 13 Darling Hill Rd; Mason NH 03048
Phone:		Phone:	603-878-2962
Student:		DOB:	
Parent:		Parent:	
Address:		Address:	

I hereby give my permission for the Release/Exchange of relevant records and information, as described below, regarding my child to the Mason School District. The release entitles the Mason School District to send or receive written documents and to orally communicate information concerning my child.

- ☐ Academic
- ☐ Educational Records
- ☐ Attendance Records
- ☐ Medical Records
- ☐ Health Records
- ☐ Minutes of Meetings
- ☐ Observations
- ☐ Progress Reports
- ☐ IEP
- ☐ SPED Files
- ☐ Psychological Testing
- ☐ Educational Testing
- ☐ Speech/Language
- ☐ Other: _____
  _____

This information will be used for the following purpose: _____

_____

_____

- I understand I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless revoked, the automatic expiration date will be twelve (12) months from the date of signature.
- I understand that the information authorized for release may include protected health information and/or student treatment/education records related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.
- I understand that I do not have to sign this Authorization and that Mason School District may not condition treatment, or education plans on whether I sign this Authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.
- I understand that the school district will not release any personally identifiable information regarding my child except with written permission specifying the records to be released, reasons for such release, and to whom the records will be released.

_____ _____ _____
Signature of Parent/Guardian/Adult Student/Surrogate Parent *Relationship to Student* *Date*

A copy of this consent shall have the same force as the original. The consent is valid for one year from the date that it is signed.