Learning Springs
Every moment a learning moment.

AUTHORIZATION TO RELEASE RECORDS AND EXCHANGE INFORMATION

Student Name:	
Student Date of Birth:	

I give consent to Learning Springs Academy to disclose the pupil records and/or to exchange information verbally and /or in writing.

Name of Agency to whom disclosure will be made:			
Contact person (if applicable):			
Address:			
Phone:		**Fax:**	
Purpose of Discloser:			
I authorize the following method(s) to disclose and exchange pupil record information (check all that apply):	☐ Written documents	☐ Verbal exchange	

The specific information to be released and/or exchanged is (check all that apply):

☐ **Progress Records** (including grades, test results)	**Special Education Disclosure:**	**Other** (check all that apply or specify):
☐ **Behavior Records:** (including test results, disciplinary records, incident reports, psychological test results, special education record, behavioral plan)	☐Individual Education Programs (IEPs) ☐Diagnosis ☐Summary of psychosocial & psychiatric history ☐Educational assessment and/or behavioral reports (includes school observation & educational testing) ☐Results of psychological testing ☐Medical information ______________________ ☐Other: ______________________ ______________________	☐Attendance records ☐Progress reports ☐Enrollment ☐Psychological records ☐Agency reports (such as Dept. of Children and Families or law enforcements records) ☐Written communication ☐Other (specify) ______________________ ______________________ ______________________
☐ **Student Health Records:** (including accident/injury reports, health screening records, individual health plans, vision screening, physical cards, immunizations)		

Time period for which records are requested: _________ to ___________ or ☐ Entire Enrollment

I further understand that:

1. I/We have the right to a copy of the records that are disclosed and a right to a copy of this authorization.
2. I/We have a right to revoke this authorization, except to the extent that disclosure has already been made in reliance on this authorization. I understand that my/our revocation is effective only if it in in writing and it is submitted to the agency that is releasing information.

3. I/We understand that both custodial parents/guardians must submit only one form per agency.
4. I/We understand that the information to be disclosed is protected under the Lanterman-Petris-Short Act (CA, Welfare & Institutions Code section 5000 et seq., 1999) and the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and cannot be re-released to any other entity or individual without my additional signed consent unless otherwise provided by the regulations.
5. I/We understand that modifications and/or changes may not be made to this form prior to submission. Any request for modification and/or change must be submitted in writing to the Executive Director for review/approval.
6. I/We understand that both custodial parents/guardians must sign and date this form upon submission and/or revocation.

This authorization is valid until September 15 of the subsequent school year unless revoked as described above. A copy of this form is as effective as that of the original. I/We certify that I/We are/am the Parent(s)/Legal Guardian(s) of the Student and have the authority to sign this release.

Signature of Parent #1/Legal Guardian #1:_______________________________ Date: ________

Printed Name of Parent #1/Legal Guardian #1: ____

Signature of Parent #2/Legal Guardian #2: ______________________________ Date: ________

Printed Name of Parent #2/Legal Guardian #2: ____

Signature of Executive Director: _______________________________________ Date: ________

School use only: □Filed in Cumulative Folder