



Wayland Union Schools

Administration Office | 893 E. Superior St. Wayland, MI 49348 | Office: (269)792-2181 | Fax: (269) 503-8877

Parental Authorization for Release of Information

This form must be completed fully for exclusive WUS personnel to discuss and/or obtain information with your child's identified provider below. A new parental authorization for release of information form must be completed for each specialization of provider (i.e. neurologist, endocrinologist, etc.), and each time there is a change in your child's providers.

Student Demographics

Name of Student: _____ DOB: _____ School: _____

This release expires on ____/____/____ or when the student above is no longer receiving services from WUS.

Reports/Information Requested to be Released to WUS

(select all that apply)

- | | |
|---|--|
| ☐ Health Records, specifically _____ | |
| ☐ OT/PT | ☐ Psychological |
| ☐ Social Work | ☐ Vision/Hearing |
| ☐ Speech/Language | ☐ Educational Assessment |
| ☐ Psychiatric | ☐ Teacher Evaluation/Comments |

School/Provider Information & Parent/Guardian Statement Authorization

FROM/TO:

Wayland Union School Nurse

Building Name: Support Services

Address: 850 E. Superior St. Wayland, MI 49348

Office Phone: (269) 792-2181 Ext. 3006

Fax #: (269) 503-8877



FROM/TO:

Provider Name: _____

Office Name: _____

Address: _____

Office Phone: _____

Fax #: _____

I, _____ (parent/guardian name), hereby authorize _____ (student's physician) to release confidential information received to be used by Wayland Union Schools for the exclusive use of professional personnel in the educational planning for my child, _____ (student's name), and is subject to the Family Educational Rights and Privacy Act of 1974, 20 USC 1232g.

Revocation Rights

I understand that I have the right to revoke this authorization at any time by presenting my written revocation to Wayland Union Administrative Staff. Revocation will not affect any information which may already have been released or received, but future information sharing will cease upon receipt of my revocation. Educational rights and services may not be withheld by my declining to sign or revoking this release. I also understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by the Health Insurance Portability Act (HIPAA), but will be covered by the Family Educational Rights and Privacy Act which regulates redisclosure of the information by school districts.

Parent/Guardian Signature: _____ **Date:** _____