NORTHEAST INDIANA SPECIAL EDUCATION COOPERATIVE
1607 E. Dowling Street
Kendallville, IN 46755
(260) 347-5236 1-800-589-5236 FAX (260) 347-1657

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I request and authorize Northeast Indiana Special Education Cooperative and					**(school)**
authorized personnel	◯	**to release to**	◯	**to obtain from:**	
Agency Address:		**Phone:**		**Fax:**	
Information regarding (student name):				**DOB:**	
Student Address:					
For the purpose of:					
Treatment Dates: (for mental health and medical)					

INFORMATION TO BE RELEASED

Parent Is to Initial Which of the Following Apply:

YES	NO	
		Attendance
		Initial Assessments
		Medications
		Progress Reports
		Psychiatric Evaluation
		Recommendations

YES	NO	
		Summary of Contacts
		Termination Summary
		Testing Reports
		Treatment Plan/Review
		Unrestricted access to record
		Other: observation & evaluation

WAIVER OF SIXTY DAY EXPIRATION OF CONSENT TO RELEASE INFORMATION

I have been informed that the State of Indiana: 16-4-8-2 restricts consent to release of information to a sixty-day period following the date of my signature. However, the specific purpose of this release extends beyond the sixty-day period following my signature. Therefore, I expressly waive my right to the sixty-day limitation and authorize this consent to continue until the purpose of the release is fulfilled, the annual case conference, or until / / whichever comes first.

I authorize a waiver of the sixty-day expiration period (parent signature):

I hold harmless Northeast Indiana Special Education Cooperative in regard to the use of information authorized for release or exchange. I understand that this form is not required as a condition for treatment and that it may be revoked by me in writing at any time, except to the extent that action has already been taken. In the absence of revocation, this consent will expire sixty (60) days from the date of valid signature except in the event I have signed a waiver extending the consent beyond the sixty-day period. **I HAVE READ AND UNDERSTAND THE ABOVE AND ACKNOWLEDGE THAT IT WAS PROPERLY COMPLETED PRIOR TO MY SIGNATURE.** A photocopy of the authorization is authentic as the original signed Authorization for Release of Information.

Client's Signature:		**Date:**	
Parent/Guardian Signature:		**Date:**	
Witness Signature:		**Date:**	

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal Rules prohibit any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. **NOTE: Should you require your own release of information form, please send us one and we will be happy to utilize it.**