HURON VALLEY SCHOOLS
building futures... one student at a time.

Milford High School
Student Support Services
2029 N. Milford Road Highland, MI 48357-3815
248-684-8236 Fax 248-684-8229 www.huronvalley.k12.mi.us

RELEASE OF STUDENT INFORMATION

Student Name:_____ Date of Birth: _____

I, the undersigned, hereby authorize Huron Valley Schools to:

RELEASE TO: _____ OR RECEIVE FROM: _____

Name / Agency: _____

Address; _____

_____

Phone: _____

Fax: _____

☐ Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results.

☐ Medical and/or related records.

☐ Psychological evaluations or social work reports.

☐ IEP team evaluations and related reports.

☐ Appropriate agency reports.

☐ Individualized education program.

☐ Other_____

Purpose: This information will be used for the following:_____

Authorization

This authorization is valid for one calendar year. It will expire on _____(insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Act and may become education records protected by the Family Education Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____
Parent Signature Date

_____
Student Signature (for students 18 years and older) Date

_____
H,V.S. Staff - Building Date

Has this release been handled by the building: ☐ YES ☐ NO

Copies: Parent or student
Physical or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

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