Parkview Academy of Virtual Education
408 West Beloit Ave., Orfordville WI 53576
(608) 879-2994 ext. 7000

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Student information	**Person Authorized to Consent**
Name:	Name:
Date of Birth:	Relationship to Student:
Address:	Address & Phone Number:

This consent authorizes the Parkview Academy of Virtual Education to release and receive information from the following:

Name of agency, provider, or individual:
Address:
Phone/Fax/Email:

Specific Information to be Disclosed (check all that apply):

- ☐ Educational Records Including Attendance, Behavior, and Individual Education Plans/504 plans
- ☐ Medical Records Pertaining to Diagnostic and Treatment Records
- ☐ Medical Records Pertaining to Progress Notes
- ☐ Medical Records Pertaining to Discharge Summaries
- ☐ Mental Health Diagnostic and Treatment Records
- ☐ Physical Therapy, Occupational Therapy, Speech & Language Records
- ☐ Alcohol & Other Drug Evaluation and Treatment Records
- ☐ Human Service and Juvenile Court Records
- ☐ Other _____

Purpose for Release of Information (check all that apply):

- ☐ Coordination/Continuation of Care including phone consultation
- ☐ Educational Evaluation
- ☐ School Related Health Planning
- ☐ Request of Student and/or Parent/Guardian
- ☐ Transfer of Education Records
- ☐ other: _____

Please review and acknowledge your understanding of your rights with respect to this authorization:

I have reviewed this form and I understand and acknowledge that:
By signing this consent for release of confidential information, I am confirming that I understand the following:
My records may be protected under State and Federal Regulations governing confidentiality.

- Education – Family Educational Rights and Privacy Act (FERPA) 20 U.S.C. § 1232g; 34 CFR Part 99
- Mental Health – Sec. 51.30, Wis. Stats. & HFS 92, Wis. Admin. Code
- Alcohol & Other Drug Abuse – 42 CFR, Part 2; Sec. 51.30, Wis. Stats. & HFS 92, Wis. Admin. Code
- Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, pts 160 & 164

Right to Copy and Inspect: I have a right to receive a copy of this release and to inspect/receive a copy of materials to be disclosed by this form.
Redisclosure Notice: The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is disclosed, the recipient of the redisclosed information may be controlled by different laws. I recognized that these records, once reviewed by the school district, may not be protected by the Health Insurance Portability and Accountability Act (HIPPA) and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25 (2m)(a)(b) and 146.82 – 146.83.
Right to Revoke: I have a right to revoke this authorization at any time understanding that it will not impact information that has already been released. A request to revoke this release must be made in writing and provided to Parkview Academy of Virtual Education.
Voluntary Consent: My consent to the release of the confidential records described above is voluntarily given. Refusal to sign this authorization will not affect my right to receive educational services. I am under no obligation to sign this form, and my refusal to sign will not affect treatment, enrollment, or benefits for me or my child (if applicable).
Expiration: This authorization is valid for one year from the date of signature unless otherwise indicated here: _____.
This authorization is valid for one year and covers records created after I sign this form unless I revoke the form sooner. I may revoke this authorization, in writing, at any time. However, the revocation will not affect disclosures that occur before my revocation.

I acknowledge that I have had an opportunity to review and ask questions about this form and that I understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. A copy of this form is as effective as the original.

I hereby authorize the disclosure of records to the named persons or entities, as specified above.	
Signature-Parent/Guardian or Other Person Legally Authorized to Consent to Disclosure	**Date Signed**
Signature-Minor Student (only if legally required)	**Date Signed**