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Authorization To Exchange/Redisclose Communications And Records

To: Name, Organization, Address, City, State, Zip
Re: Name(s), Date(s) of Birth, Address, City, State, Zip

The affixed signature(s) authorizes \_\_\_\_\_ and the Agency or Person to whom this form is addressed to exchange restricted/confidential communications and records as listed regarding the above-named individual(s).

The purpose for the exchange/disclosure is \_\_\_\_\_, and is accessible for inspection and copying upon request.

The person(s) authorizing the exchange/redislosure of communications and records has the right to revoke this consent by written statement at any time. Information released prior to revocation is not affected.

This Authorization To Exchange/Redisclose Communications And Records is valid until \_\_\_\_\_. (One year is often used for ongoing collaboration when coordination of care is warranted.)

Failure to sign this form will prevent the exchange/redislosure of communications and records, and may result in a disruption in the continuity of your child's educational progress.

List type(s) of communication(s) and record(s) to be exchanged/redislosed. (If mental health records are being sent, identify them according to agency, type of information, and dates of reports.) \_\_\_\_\_

Signature(s) required: individuals age 12 or older; parent/guardian if child is less than age 12; child only if age 12-17 and receiving substance abuse treatment without parent consent.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_
(Signature of witness who can verify the signee's identity)

Signatures indicate awareness of the nature and content of the communications and records being exchanged or redislosed. By signing this document, I understand that once my health information is disclosed to the recipient, it cannot be guaranteed that the recipient will not redislose my health information. However, according to FERPA, Benjamin School District 25 will require an additional consent form to be signed in order to redislose this information beyond what may be necessary to share with school personnel.

Note to receiving agency: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act and the Federal Confidentiality Rules (42-CFR Part 2), no such records, nor information from such records, may be further disclosed without specific authorization for such redislosure.