



# Authorization for the Release of Information (ROI)

Student: \_\_\_\_\_ CIF: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone (Home/Work/Cell): ( \_\_\_\_\_ ) \_\_\_\_\_ Phone (Home/Work/Cell): ( \_\_\_\_\_ ) \_\_\_\_\_

I authorize Saint Paul Public Schools, District # 625, \_\_\_\_\_

*Person(s) Responsible*

\_\_\_\_\_ St. Paul, MN \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
*Street Address* *Zip Code* *Phone*

Please  all that apply:  To release information to:  To obtain information from:

Site Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

### The following information is requested:

- |  |  |
|--|--|
| <input type="checkbox"/> Health Histories              | <input type="checkbox"/> Allergies                             |
| <input type="checkbox"/> Physical Examination Reports  | <input type="checkbox"/> Audiology Reports                     |
| <input type="checkbox"/> Immunization Records          | <input type="checkbox"/> Vision Reports                        |
| <input type="checkbox"/> Office/Clinic Visit Notes     | <input type="checkbox"/> Consultations                         |
| <input type="checkbox"/> Admission/Discharge Summaries | <input type="checkbox"/> Other <i>(please specify)</i> : _____ |

### The purpose of this request is:

- to facilitate evaluation of your child's individual educational program.
- to determine health needs of your child which may require attention during school.
- to provide school personnel with a better understanding of your child's health needs.
- to allow professional consultation.

### Statement of Authorization:

- I understand that the authorization takes effect the day that I sign it and expires one year from the date of my signature.
- I understand that I may revoke this authorization at any time by giving written notification.
- It is the practice of Saint Paul Public Schools to not re-disclose records without consent.
- A photocopy/fax of this authorization which has not been altered will be treated in the same manner as the original.
- Services are not conditioned upon this release of information.

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Relationship to Student*

\_\_\_\_\_  
*Date*

We Are Neither Authorized Nor Funded To Pay For This Information.