ATLANTA PUBLIC SCHOOLS
Making A Difference

Department of Special Education / Student Support Team Compliance / Section 504
Authorization to Release Confidential Information

TO: _____ DATE: _____

_____

_____

_____

RE: _____ _____
Last Name First Name Middle D.O.B

_____
School attended in your system

In order to assist in the educational / health planning and placement of the student named above, you are hereby authorized to release the following reports/information.

_____ Psycho/Educational Evaluations
_____ Section 504 Documentation
_____ Speech and Language Evaluations
_____ Audiological Report
_____ Pre-Referral Intervention Information
_____ Other _____

_____ Instructional Plans
_____ Accommodations Plans
_____ Meeting Minutes
_____ Eligibility Report
_____ Vision Report
_____ Completion of APS Medical Packet

These records should be sent to: _____

_____

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- *Parent(s) / guardian(s) by signature below acknowledges that the school is providing for the administration of medication / medical procedure as a courtesy to the parent(s) / guardian(s) and agrees to hold the school and school system harmless in its so doing.*
- *Additionally, authorization is granted to obtain pertinent medical and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent staff as needed for the purpose of educational / health planning.*
- *I understand that effective April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPPA"), disclosure of certain medical information is limited. However, I herein authorize disclosure of pertinent medical information for the provision of services for my child while in attendance in the Atlanta Public Schools District. This authorization expires as of the last day of this school year, including the summer/ extended year session.*

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Student