Bedford County Public Schools
310 South Bridge Street, Bedford, VA 24523
Phone (540) 586-1045

AUTHORIZATION FOR CONFIDENTIAL RELEASE AND EXCHANGE OF EDUCATION AND HEALTH RECORDS

LEGAL FULL NAME OF STUDENT/PATIENT	STUDENT/PATIENT DATE OF BIRTH

Physician	ADDRESS	PHONE NUMBER	FAX NUMBER

OFFICIAL REQUESTING RECORDS/TITLE	ADDRESS	PHONE NUMBER	FAX NUMBER
JFHS clinic staff/ administration	**Jefferson Forest High School #1 Cavalier Circle Forest, VA 24551**	**434-525-2674**	**434-477-5459**

I request release or exchange of the following information on my child or ward to the official stated above for the purpose of:

Management of medical conditions to include any physical &/or academic accommodations.

✓CHECK ALL THAT APPLY:

☐ Official Scholastic Record (includes: student name/address, parent's names/addresses, certified copy of birth certificate (Code of Virginia § 22.1-3.1C) or birth certificate number as recorded by another VA public school, birth date, grade level completed, class standing, attendance record, Student Testing Identifier (STI), extracurricular activities, citizenship, if other than the United States, etc.)

☐ Scholastic grades (historical and withdrawal grades with grading scale) ☐ Discipline record

☐ Group and individual intelligence, achievement, aptitude and interest test scores (includes: SOL, AP, PSAT, SAT, ACT, Stanford 10, Olsat, Naglieri, etc.)

☐ Limited English Proficient (LEP) records ☐ Talented and Gifted (TAG) records

☐ 504 records, Individualized Education Program (IEP), latest eligibility minutes, eligibility summary, SCT information, evaluation reports and functional behavioral assessments.

☐ All health records listed below:

✓ Physical and immunization records with dates signed by doctor or school nurse ✓ Lab reports
✓ Medical diagnosis ✓ Doctors orders ✓ Medical Care Plan ✓ Mental Health/Psychiatric
✓ Discharge summary ✓ Audiological/Vision ☐ Speech reports ☐ Social/Cultural
☐ Psychological reports ☐ Fitness data

☐ Others (please specify): _____

_____

_____

This authorization is valid for one year unless specified otherwise. It will expire on _____.
I understand that I may withdraw this authorization by submitting written notice to the school/agency/person releasing records stated above. I understand that health records, once received by the school district, may no longer be protected by HIPPA, but they will become education records protect by the Family Educational Rights and Privacy Act (FERPA). I have the right to request a hearing to challenge the content and accuracy of these records on the student/patient named above.

_____ _____
SIGNATURE OF PARENT/GUARDIAN/LEGAL CUSTODIAN OR ELIGIBLE STUDENT DATE

Va. Reynolds, RN
SIGNATURE OF SCHOOL OFFICIAL COMPLETING

REVISED AUGUST 2011