

# *Ridgway Area School District*

## **WRITTEN AUTHORIZATION TO REQUEST / RELEASE STUDENT RECORDS TO AN AGENCY**

### **What is the Purpose of This Form?**

This form is used to obtain parental permission to request records or release records to another agency other than a school district. Examples of agencies are: Beacon Light Behavioral Health Systems, Dickinson Mental Health Center, Doctor's Offices, Hospitals, etc.

### **Who Should File This Form?**

Administrators and guidance counselors should use this form when they become aware of services that a student is receiving or has received from another agency.

### **When Should this Form be Filed?**

Immediately upon knowledge of other service providers in order for the district to better understand the student and his/ her needs. This form should also be completed if the parent / student requests his/her school records be sent to another agency.

### **Special Notes:**

This forms need to be kept on file. They should be placed in the Category B file – not in the student's Category A file (Permanent Record).

Revised: Oct 2022

**RASD** RIDGWAY AREA SCHOOL DISTRICT **RASD**  
62 SCHOOL DRIVE  
RIDGWAY, PA 15853

**IMPORTANT:** Send information to the attention of the office selected below using the above mailing address:

ELEMENTARY OFFICE  
TEL: 814/776-2176  
FAX: 814/776-4247

MIDDLE/HIGH SCHOOL OFFICE  
TEL: 814/773-3164  
FAX: 814/773-3115

OFFICE OF STUDENT SERVICES  
TEL: 814/776-4255  
FAX: 814/776-4298

**WRITTEN AUTHORIZATION TO REQUEST / RELEASE STUDENT RECORDS**

TO: \_\_\_\_\_ DATE OF REQUEST: \_\_\_\_\_  
\_\_\_\_\_  
RE: \_\_\_\_\_ STUDENT DOB: \_\_\_\_\_

**Request / Release to an Agency**

The following information is  
requested / released in order to: \_\_\_\_\_

_____ Psychiatric Reports (May include PHI*)	_____ Progress Notes (May include PHI*)
_____ Psychological Reports (May include PHI*)	_____ Academic Records
_____ Medical Treatment / History (May include PHI*)	_____ Special Education Records (May include PHI*)
_____ Social Casework Reports (May include PHI*)	_____ Probation (May include PHI*)
_____ Counseling / Therapy Records (May include PHI*)	_____ Discharge Summary (May include PHI*)
_____ Intake Data & Social History (May include PHI*)	_____ Recommendations (May include PHI*)
_____ Individual Service/Treatment Plan (May include PHI*)	_____ Exchange of Verbal Information (May include PHI*)
_____ Other: _____	

**\*PHI – Protected Health Information**

I/We understand the following:

- The designated information will be exchanged with the understanding that absolute confidentiality will be maintained.
- Photocopies of this authorization shall be considered valid.
- This written authorization shall expire one year from the date signed.
- This written authorization may be revoked at any time by notifying, in writing, the Privacy Officer in the Office of Student Services at the above address.
- The identified agency and its staff/employees have no responsibility or liability as a result of any re-disclosure.
- I/We are entitled to a copy of this Written Authorization form.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE OF SIGNATURE

\_\_\_\_\_  
SIGNATURE OF STUDENT\*

\_\_\_\_\_  
DATE OF SIGNATURE

*\*If s/he is age fourteen (14) or will be age fourteen (14) during the duration of this release.*

Thank you for your assistance and timely attention to this request. Please send records to the attention of  
\_\_\_\_\_ at the office specified above.