

Student Name: _____

Student Grade: _____

Authorization for the Release of Educational Records

Last School of Record: _____

Address: _____

Phone: _____

Fax Number: _____

To Whom it May Concern:

The following student has enrolled at our school. Please send all records including copies of the cumulative files, grades, courses taken, test scores, special education plans, current individualized education plan (IEP), health records, immunizations dates, psychological and/or Social Worker reports, mental health records, discipline records, and behavioral threat assessments if any. Additionally, please include all current grades earned this school year and/or withdrawal grades, if any.

Student Name		Date of Birth
Primary Parent / Guardian	Primary Phone	Secondary Phone

Please send these records to:

Alee Academy Atten: Registrar
1705 E CR 44
Eustis, Florida 32736

Phone: 352-357-9426
Fax: 352-357-8426

Security and confidentiality of education, health, and medical records are of critical importance to Lake County Schools. Information contained in a student's educational record is protected by the Family Educational Rights and Privacy Act (FERPA) of 1974 (20 U.S.C. §1232g). "Education record" includes those records, files, documents, and other material that contain information directly related to the student and are maintained by Lake County Schools or a person acting on behalf of Lake County Schools. The Health Insurance Portability and Accountability (HIPAA) of 1996 Privacy Rule (Code of Federal Regulations, Title 45, Part 164) governs how "covered entities" may use and disclose "protected health information." Lake County Schools personnel adhere to all regulations contained in relevant Federal laws and Florida statutes.

Your authorization to release this information is strictly voluntary. You may revoke your authorization for release in writing at any time by providing a written revocation to Lake County Schools. However, any written revocation will not apply to any information already released in response to this authorization. **Without any written revocation, this authorization will remain in effect for one (1) year.**

You have a right to inspect and obtain a copy of any information disclosed. You acknowledge that once disclosed, protected health information may be subject to redisclosure by the recipient, and may no longer be protected by HIPAA's privacy rules.

Per FERPA, educational records requested from a receiving educational institution do not require parent signature for release.

I understand that by signing this authorization, I am waiving my rights of nondisclosure of these records under federal and Florida law only to the persons or entities specifically listed.

I, _____ (Parent/Guardian/Eligible Student), hereby give my permission for _____ to share records by verbal, written, or electronic means with the Lake County Schools' personnel. (School/Agency)

Signature: _____ Date (MM/DD/YYYY) _____