Greater Lafayette Area Special Services
(G.L.A.S.S.)
2300 Cason Street
Lafayette, Indiana 47904

Phone: (765) 771-6006 Fax: (765) 771-6077

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

Authorization for Mutual Release of Protected Health and/or Educational Information

I hereby give permission for a mutual exchange of information between Greater Lafayette Area Special Services (GLASS) and the following AGENCY OR MEDICAL PROVIDER:

(Agency or Medical Provider) **(Phone Number)** **(Fax Number)**

Regarding my child:

(Child's Name) **(Date of Birth)** **(Grade Level)**

(Street Address) **(City)** **(State)** **(Zip Code)**

The information requested (please check all that apply):

- ☐ School Health & Immunization Records
- ☐ Psycho Educational Evaluations
- ☐ I.E.P. (Individual Education Plan)
- ☐ Behavioral Observations
- ☐ Case Conference Summaries
- ☐ Medical History
- ☐ School Achievement Records
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Effective from _____ to _____

(Starting Date of Exchange) **(Ending Date of Exchange)**

Greater Lafayette Area Special Services (Please circle one of the offices below.)

Attention of: _____
GLASS @ Linnwood
1415 Ball Street
Lafayette, IN 47904
Phone: (765) 476-2900 Fax: (765) 476-2906

Attention of: _____
GLASS @ Hiatt
2300 Cason Street
Lafayette, IN 47904
Phone: (765) 771-6006 Fax: (765) 771-6077

The information is being requested for the purpose of treatment/health care of the child.

I understand that GLASS may not require me to sign this Authorization as a condition of providing health care/treatment/services to my child.

I understand that this Authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on this Authorization, in order to revoke this Authorization, I must deliver a revocation in writing, to GLASS and that after such revocation is delivered to GLASS, no further information will be released pursuant to the Authorization.

When my information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Signed: _____ _____
Signature Relationship to Student

_____ _____
Print Name of Person Giving Consent Address

_____ _____
Phone Number (Home) Phone Number (Work)