Dodgeville School District
307 N. Iowa Street
Dodgeville, WI 53533
Telephone: (608) 935-3307, ext. 5010   Fax: (608) 935-3021

Dear ________________________________________

In order for us to exchange information regarding your child/family, ________________________________, please complete and return one copy in the self-addressed, stamped envelope that is included and keep the other copy for your files. If you have any questions, contact me at (608) 935-3307 Ext. 5020.

Sincerely,

Carrie Pyka - School Liaison Homeless Coordinator
Name & title of school district contact person __________________________ Date ________________

PARENT PERMISSION TO OBTAIN OR RELEASE INFORMATION

I hereby authorize ________________ to exchange with (check all that apply)

____ Iowa County Dept. Social Services  __________ Iowa County Commission on Aging
____ Social Security Administration Office    __________ Iowa County Veteran’s Office
____ Dodgeville Housing Authority  __________ Iowa County Health Department
____ Iowa County Job Center  __________ Lutheran Social Services
____ Family Advocates  __________ Unified Community Services
____ Southwestern WI Community Action Program (SWCAP)  __________ Passages

the information indicated below:
(school, agency, health provider, etc.)

☐ Official student academic/administrative records (identifying information, grade level, completed grades, class rank, attendance records, and group aptitude test results)

☐ Medical and/or related health records

☐ Psychological/ Psychiatric evaluations or social work reports

☐ Evaluation and Reevaluation reports

☐ Appropriate agency reports

☐ Individualized education program (IEP’s)

☐ Current living arrangements.

☐ Others (specify) ____________________________________________

This information will be used for the following purpose(s):

☐ Educational evaluation and planning

☐ Coordination of services

☐ Other (specify) ____________________________________________

This permission is valid for one year from the date signed unless otherwise stated here: ________________ (alternate date)

This permission may be revoked in writing at any time prior to the exchange of information. I recognize that once the information is exchanged, it may no longer be protected by the HIPAA Privacy Act and may be subject to re-disclosure.

_________________________________________ Date __________________
Signature of student (if own legal guardian or over 18 years of age)

_________________________________________ Date __________________
Signature of person authorized to act for the student