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 **Dodgeville School District**

to exchange with (check all that apply)

_____Iowa County Dept. Social Services
_____Social Security Administration Office
_____Dodgeville Housing Authority
_____Iowa County Job Center
_____Family Advocates
_____Southwestern WI Community Action Program (SWCAP)
_____Iowa County Commission on Aging
_____Iowa County Veteran's Office
_____Iowa County Health Department
_____Lutheran Social Services
_____Unified Community Services
_____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.

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

_____ _____
Signature of person authorized to act for the student Date