STATE OF HAWAI'I
DEPARTMENT OF EDUCATION

CONSENT FOR RELEASE OR RECEIPT OF STUDENT RECORDS

Student's Name: _____ Date of Birth: _____
Last Name First Name Middle Initial

I grant permission to the State of Hawai'i Department of Education, _____
Name of DOE School or Office

_____
Address City State Zip Code

_____
Department of Education Contact Phone Number Fax Number

To: ☐ RELEASE ☐ RECEIVE (Check one)

the following document(s)/information,(listed below) on the above named student, except that which is legally not subject to disclosure by any applicable law, and is covered under the Hawai'i Revised Statutes, §325-101 Infections and Communicable Diseases (HIV Infection, ARC, and AIDS); §329-68 Uniform Controlled Substances Act (Protection of records; divulging confidential information prohibited) and §329-B6 Substance Abuse Testing (Test Results) to or from the agency and/or individual listed below:

_____
Name of Agency or Individual Phone Number

_____
Address City State Zip Code

Specify document(s)/information authorized for release and/or receipt:

For the purpose of:

I understand that a student's education records are confidential and may only be disclosed as allowed by Family Educational Rights and Privacy Act of 1974 (FERPA) prohibits release of this information without the written consent of the student's parent or eligible student. (An "eligible student" is a student who is at least 18 years of age). I recognize that health records, once received by the school and/or the State of Hawaii Department of Education may not be protected by Health Insurance Portability and Accountability Act of 1996 Privacy Rules but will become educational records protected by FERPA.

I understand that my consent is voluntary and I may withdraw my consent at any time by submitting written notice of the withdrawal of my consent to the above-listed school's administrator. If I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

I hereby authorize the transfer of information as indicated above. This authorization is valid for one year from the date listed below unless the school is otherwise notified in writing.

_____ _____
Parent or Eligible Student Signature Date

_____ _____
PRINTED Name of Parent orEligible Student Phone Number

_____
Address City State Zip Code

To the receiving agency/individual: The above listed document(s)/information will be transmitted to you or your agency only on the condition that it not be shared with another agency or other person(s) without the written consent of the parent or eligible student. The officers, employees, and agents of a party that receives the above listed document(s)/information may use the document(s)/information only for the purposes for which the disclosure was made. Please return the documents to the above-listed school if you are unable to comply with this condition.

DISTRIBUTION: School Parent Receiving Agency/Individual