1690 Woodland Drive, Suite 200
Maumee, OH 43537
PH: 1.419.482.0948
FX: 1.440-209-7798

ohva.k12.com

Request for Release of Records

Student's Full Name: Click or tap here to enter text.
Student's Date of Birth: Click or tap here to enter text.
Student ID: Click or tap here to enter text.

I authorize the following provider: Click or tap here to enter text.
Located at (provider's address): Click or tap here to enter text.
Provider's phone number: Click or tap here to enter text.
Provider's fax number: Click or tap here to enter text. to
☐ Receive information from
☐ Disclose information to
the following individual along with any Ohio Virtual Academy staff member who impacts the student's educational performance:
OHVA Staff Member's Name: Click or tap here to enter text.
OHVA phone: 419-482-0948 ext: Click or tap here to enter text.
OHVA SPECIAL EDUCATION Fax: 440-209-7798
Address: Ohio Virtual Academy, 1690 Woodland Dr., Second Floor, Maumee, OH 43537
☐ Receive from
☐ Disclose to

The following information may be disclosed
(Check All that Apply)
☐ Diagnosis/Diagnostic impressions
☐ Written Report (if one available)
  ☐ Immunization Record
☐ Recommendations
☐ Progress
☐ Additional information: Click or tap here to enter text.

Purpose of receiving or disclosing information is to:
(Check All that Apply)
☐ Assist with testing

Assist with therapeutic needs
☐ Provide evaluation
☐ Educational relevance
☐ Other Click or tap here to enter text.

Additional information:
The information may be release in the following form:
☐ Written
☐ Verbal
☐ Fax
☐ Conference or Observation
☐ Video or Audio Tape

This release covers the duration of treatment for a period of one year, unless otherwise stated below:
Expiration date, if other than one year: Click or tap here to enter text.

Consent of Parent or Guardian for Release of Information

I authorize Ohio Virtual Academy to exchange information and records as indicated. Except as limited above, this authorization encompasses all information pertaining to the minor, including protected health information (PHI) as defined in the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations, and education records as defined in the Family Education al Rights and Privacy Act (FERPA) and Ohio Revised Code Section 3319.321. We expressly waive all provisions of law (including, but not limited to, the privacy provisions of HIPAA, FERPA, and R.C. 3319.321) forbidding any physician or other person who has or may hereafter treat, attend or examine the minor, or any educational agency, from disclosing any knowledge or information, including PHI, which they may have thereby acquired. I understand that the disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Student Signature (if applicable): _____ Date: _____ /_____/_____

Parent/Guardian Signature (if applicable): _____ Date: _____ /_____/_____

Revocation of Consent

Parent/Guardian/Student Signature:___ Date: _____ / ____ / ____

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