

Utah Public Schools – Autism Educational Classification – Medical Information Release

This form will authorize the exchange of information between the student’s health professional(s) and school professionals as it relates to the diagnosis/classification of autism. A diagnosis of autism is not required for the IEP team to determine that the student meets the eligibility criteria for the autism educational classification. However, the IEP team must obtain prior medical history regarding specific syndromes, health concerns, medication and any information deemed necessary for planning the student’s education. *When completed, this form should be provided to the school principal and a copy should be returned to the medical provider.*

Release of Information	Student’s First and Last Name:		Parent/Guardian’s Name:		Phone Number:	
	Birthdate:					
	Student’s School & District:		Principal’s Name:		School Phone Number:	
	I, the undersigned, authorize the release of information relating to the diagnoses/conditions listed below and prior medical history regarding specific syndromes, health concerns, medication and any information deemed necessary for planning the student’s education program for the above-named student to his/her Local Education Agency (LEA) representative (school principal or designated appropriate school personnel). I also authorize the school to release and discuss information and reports with the named health professional(s) and/or assigned office personnel.					
	Parent/Guardian’s Signature:			Date:		If applicable, my consent expires:
Parents have the right to determine whether any information should remain confidential and not be included for purposes of this release. Please inform the appropriate professional of information that should not be released.						
School Information	LEA’s Name:		LEA’s signature:		Date:	
	Best Initial Contact Person:			Position:		
	Mailing Address:			Phone:		
	E-mail Address:			Fax:		
Health Professional Contact Information	Health Professional’s Name:		Phone Number:		Fax Number:	
	Role:					
	Mailing Address:		E-mail address:			
	If not you, who is the best contact person?		Phone Number:		Fax Number:	
	Mailing Address:		E-mail address:			
Preferred method and time for contact:						
Diagnostic Information	Diagnoses/Conditions: <i>Please list all that apply including co-morbid conditions</i>					
	Could these conditions adversely affect this student’s educational performance? ___ NO ___ YES Briefly describe your perceived impact:					
	Health Professional’s Signature:				Date:	