

**DOUGLAS COUNTY SCHOOL DISTRICT
SECTION 504 GRIEVANCE DISPOSITION**

This form is to be completed by the Level I building principal, and if a review is requested, by the Section 504 compliance coordinator who conducted the Level II review. The person completing form should retain one copy. Forward one copy to the grievant. File one copy with the district's Section 504 compliance officer and the Superintendent.

This Grievance Disposition is in answer to the Notice of Section 504 Grievance filed as follows:

Date Grievance filed: _____
Person who filed Grievance: _____
School where student attends: _____

Disposition of Grievance:

Signature: _____ Date: _____

If grievant wishes to appeal this decision, he or she should contact the Section 504 Compliance Coordinator at (775)265-5262. Address: Douglas County School District, P.O. Box 1888, Minden, NV 89423.

(DCSD letterhead)

Patient/Student Name: _____

Date of Birth: _____

I hereby authorize _____
to release my child's health information/records for the purpose listed below to:

Description:

The information to be disclosed consists of:

Purpose:

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

Authorization

This authorization is valid for one calendar year. It will expire on _____.

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent to _____ or the Douglas County School District. I recognize that these records, once received by the school district may be subject to redisclosure and may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Parent Signature

Date

Student Signature*

Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form.