



Greater Minnesota Psychological Assessments for Deaf, Hard of Hearing and Deafblind Students: Release of Information Form 2025-2026

Student Name: Gender: Male Female DOB

Student Address (street, city, state, zip):

Parent/guardian/legal representative:

Email: Phone:

Address (if different from student's):

School district: School name:

Parent/guardian/legal representative (Primary Signer)

I, _____ (parent/guardian/legal representative and "Primary Signer"),
authorize BrightWorks and the GM Launch PAD ("the Program"); including Dr. McDevitt, staff,
and subcontractors of the Program at Brightworks, 2 Pine Tree Drive, Suite 101, Arden Hills,
MN, 55112. Phone: (612) 638-1531, Email: gmlaunchpad@brightworksmn.org

Obtain from (name & address of sender):

Release to (name & address of recipient):

Student Information

The following information and documents concerning the Student listed above:

Academic information including grades and attendance	Psychological reports
Academic testing results	Psychological testing results
Behavior programs	Psychotherapy notes
Entire record, except progress notes	Service plans
Information from educational file	Special education forms
Intelligence testing results	Special education/regular education evaluation reports
Interviews with school staff	Summary reports
Medical reports	Vocational testing results
Personality profiles	Other (specify):
Progress reports	

Primary Signer's initial:

The above Psychological assessment information will be used for the following purposes:

- Psychological assessment
- Determining eligibility for Special Education Services
- Determining appropriate Special Education Category
- Providing consultation to the student's school



Providing consultation to the student & student's family
Determining eligibility for benefits or program
Case review—updating files
Developing an appropriate education plan
Other (specify):

I understand that this information may be protected by the Health Insurance Portability and Accountability Act ("HIPAA") and applicable state laws. I understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by state or federal law if the recipient is not a healthcare provider or other entity that is covered by state or federal rules.

I understand that this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my signing this authorization. I further understand that I may revoke this consent at any time by providing written notice to the Program at the address listed above, except that such revocation will not be effective to the extent that action has already been taken based on this authorization. This authorization will expire one year after the date I sign it unless earlier revoked. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have the right to receive a copy of this authorization. I understand that I have the right to refuse to sign this authorization.

Signer's relationship to the student (choose one):

Self Parent/legal guardian Legal representative Other (specify):

If you are a legal guardian or representative appointed by the court for the student, please attach a copy of the court order or appointment to receive this protected health information.

Student Signature:

Date:

Parent/guardian/legal representative signature (Primary Signer):

Date:

Witness Signature (if student is unable to sign):

Date:

After completing release of information form:

Please mail along with all other required forms to:

BrightWorks, Attention: Deanna Rothbauer, 2 Pine Tree Drive, Suite 101, Arden Hills,
MN 55112 Questions? Email: gmlaunchpad@brightworksmn.org, Phone: (612) 638-1531

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a division of the Minnesota Department of Human Services.*