Authorization for Release
and Use of Health Information

Student	Birth Date

I authorize the release of the above-named student's health information (as designated below)

From: ____ To: (Contact person) ____________________________

Address: ______________________________________ At: (School or district) __________________________

City/State/Zip __________________________________ Address: ____

The released information will be used for the following purposes (please **check** all that apply):

___ Educational	___ Medical	___Personal
___ Legal	___ Other	

Specific information to be released (please **initial** all that apply) for treatment dates ___________ to ____________.

___ Complete Records	___ Discharge Summary	___ Immunization Records
___ Consultation Reports	___ Physical/Occupational Therapy Records	___ Special Education Records
___ Psychological Reports	___ Intervention Summaries	___ Assessment Results
___ Mental Health Reports	___ Speech/Language Reports	___ Progress Notes
___ Other ______________________________		

This authorization shall remain in effect for six (6) months from the date of signing. I understand that I have the right to revoke this authorization to the school and student's physician on behalf of my minor child by providing written notice to the health care provider consistent with the health care provider's policies. Revocation does not affect releases of medical records made prior to the revocation.

I understand that the health care provider is not responsible for any further disclosures of the released information by the school/district. I also understand that the released medical records may become part of the student's education records and may be forwarded to another school in which the student seeks or intends to enroll. The school and district will protect this information in compliance with the Family Educational Rights and Privacy Act (FERPA).

Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records may be required in order for the school to implement an appropriate plan of education, learning accommodations/modifications, and/or health care.

I understand that if I authorize release of the above information to any individual or entity that is not legally required to keep it confidential, the information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996, or any other state or federal law.

I understand that I have a right to receive a copy of this form after signing, and I may inspect the information that is disclosed.

By my signature below, I authorize the release and use of the information in accordance with the rights, restrictions, and understandings above.

____ ________________________________

Signature of Parent/Legal Guardian/Student at Age of Majority Date

Authorization Expires ________________________________
Date

Copy to Parent(s) ___________________________________