**[SCHOOL NAME]**

**AUTHORIZATION FORM TO RELEASE AND/OBTAIN**

 **MEDICAL/BEHAVIORAL HEALTH INFORMATION**

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 **Student Name** **DOB** **Student ID #**

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**Home Address**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grade** **Parent Home Phone Parent Cell Phone**

**The following persons or agencies can release Health information:**

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**The following persons or agencies can obtain Health information:**

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The health information that can be released is any information about the diagnosis/and or services for the student named above from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (dates). The following information can also be released:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1986, I understand that:**

1. I am not required to sign this authorization and I can refuse to sign it.
2. In general, just because I refuse to sign this authorization, the Healthcare Provider named above can refuse to reat the student.
3. The Health Information released may be disclosed to others. The information cannot be disclosed to others if the person or agency who receives this information is also required to follow the privacy rules.
4. The allows schools to use and disclose Private Health Information (PHI) without obtaining patient/parental permission for the purposes of treatment plans, payment for services or health care operations such as scheduling appointments.
5. I may look at or copy the health information requested in this authorization.
6. I can withdraw this authorization, and any information disclosed prior to my withdrawal will not be affected.

I also authorize that a photocopy of this release be accepted with the same authority as the original. This authorization expires in one year unless I withdraw it earlier. Any person or agency receiving this information is directed to treat it as confidential in accordance with the Family Education Rights and Privacy Act (34 CFR 99).

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**Signature of Patient/Student (or Patient’s/Student’s Representative) Date**

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**Printed Name of Patient/Student (or Patient’s/Student’s Representative)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If Patient’s/Student’s Representative, relationship to Patient/Student**

**DATE REQUEST SENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BY WHOM\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RECORDS RECEIVED ON \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date)**