Authorization to Release Information

Print Form

Health Services
Mat-Su Borough School District
501 N. Gulkana
Palmer, AK 99645
P: (907) 746-9200

I hereby authorize the below Organization/Office to release the confidential information noted below regarding my student to the Mat-Su Borough School District.

_____

(Student's Last Name) (First) (Middle) (Date of Birth)

Organization /Office Name:_____ Phone:_____

Address:_____ Fax: _____

Information being requested: (Please check appropriate boxes)

Specific dates of service to be released: _____

- ☐ Verbal exchange of information
- ☐ Immunization Records
- ☐ Psychological/Educational notes & testing
- ☐ Laboratory/Radiology Reports
- ☐ Admission/Discharge Summaries
- ☐ Complete Medical/Educational Records
- ☐ History and Physical
- ☐ Observations and Ratings
- ☐ Treatment Plan
- ☐ Other _____

I acknowledge that the information to be released **MAY INCLUDE** material that is protected by Federal Law. **My initials and signature** below authorize release of the following type of information:

_____ Mental Health, if any_____ Drug abuse, if any (with signature of minor required by law)

The purpose of the receipt, use or disclosure of this information is:

_____ As needed for guidance and education planning during treatment and upon return to school

_____To determine immunization status of student

_____ Other: _____

I hereby authorize the use or disclosure of health care and/or other information as described above. I understand that this authorization is voluntary. I understand that records may contain sensitive information. I understand that I may revoke this authorization at any time by notifying the individual (s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual (s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I provide this authorization. I understand that if the person (s) organization authorized to receive this information is not a health plan or health care provider, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization. I understand that once the school receives these records, the information will become part of the student's education record and will move with the student.

This authorization expires on the following date _____ or event: _____

Means of Delivery: _____Pick-up, _____Mail, _____Fax,_____Personal Delivery

Parent/Legal Guardian Signature: _____ Relationship:_____

Date signed:_____

Student Signature: _____

(Minor's signature required if information contains information pertaining to drug abuse)

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as other wise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.