AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION TO QUINCY PUBLIC SCHOOL #172

Re: Student:_____ Birth Date:_____
Name of Provider_____ Provider's Telephone:_____
Provider's Address:_____ Provider's Facsimile:_____

I authorize the release of my child's confidential information to Quincy Public School District #172, c/o _____
_____for the following purpose_____
_____.

The information to be disclosed is as follows (check all that apply):
□ **Mental health records** (entire record including past and current history, notes, assessment, test results, diagnosis, treatment plans, medication and recommendations) (strike through any that do not apply).
□ **Medical records** (entire record including past and current history, notes, assessment, test results, diagnosis, treatment plans, medication and recommendations) (strike through any that do not apply).

The following information shall **NOT** be disclosed (check all that apply):
□ Drug/Alcohol Services □ AIDS or HIV information □ Sexually Transmitted Disease & Reproductive Health Services

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that these records, once received by the school district, may not be protected by the HIPPA Privacy Rule, but will become education records protected by the Family Education l Rights and Privacy Act. I understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I understand that I may inspect or copy the information to be used or disclosed as provided by law. I understand that any disclosed information has the potential for unauthorized re-disclose of information and may not be protected by federal confidentiality rules.

Unless otherwise revoked, this authorization will expire on _____. If I fail to specify an expiration date or event, this authorization will expire one year from the date signed.

_____ Date: _____
Parent or Legal Representative Printed Name

_____ Relationship to Student:_____
Parent or Legal Representative Signature

_____ Witness: _____
**Student if age 12 or over
**Required for mental health records

AUTHORIZATION FOR QUINCY PUBLIC SCHOOL #172 TO DISCLOSE CONFIDENTIAL INFORMATION

Re: Student:_____ Birth Date:_____

I authorize Quincy Public School District #172 to release of my child's confidential school records to:
Name of Provider_____ Provider's Telephone:_____
Provider's Address:_____ Provider's Facsimile:_____
for the following purpose_____.

I understand that the school records may include mental health records, medical records, dental records, speech/language records, social/developmental records, behavioral records, special education records as well as academic records.
The following information shall NOT be disclosed:_____.

_____ Date: _____
Parent or Legal Representative Printed Name

_____ Relationship to Student:_____
Parent or Legal Representative Signature

_____ Witness: _____
**Student if age 12 or over
**Required for mental health records