Consent for Release from Medical Providers of Health-Related Information
HIPAA Compliant Authorization pursuant to 45 CFR 164.508

Student Name ____
Date of Birth _____________________________ School ____

Information to be Released by:
Agencies/ Schools/ Persons ____
Address ____
Telephone ___________________________________ FAX ____
Name/ Position ____

Information to be Released to:

Attn:________________________
Union County Public Schools
400 N. Church Street
Monroe, NC 28112
Fax #: 704-282-2073

OR

School ____
Address ____
____
Phone ____
Fax # ____

I, ____, being the adult student, or parent and legal guardian of ____ (student), hereby authorize and direct the disclosure of my/my child's information specified herein from and to the entities listed above, and to communicate orally and in writing (with a copy to me) with each other concerning such information for the purpose of review and evaluation in connection with the provision of appropriate educational services. Specifically, I request that the designated records custodians disclose full and complete protected information, including the following:

☐ Unlimited disclosure
☐ Hearing/Audiological
☐ Pharmacy/medication records
☐ Psychoeducational evaluations
☐ Vision testing/reports
☐ Social/developmental history
☐ Speech/Language records
☐ Medicaid/Medicare records
☐ Health evaluations
☐ ADHD/ADD reports
☐ Physical therapy records
☐ Occupational therapy records
☐ Medical evaluations/records:

☐ All medical records, including, but not limited to: office notes; face sheets; history and physical examination; consultation notes; inpatient, outpatient and emergency room treatment; clinical charts; reports; order sheets; progress notes; nurse's notes; social worker records; clinic records; treatment plans; admission records; discharge summaries; diagnoses; prescriptions; requests for and reports of consultations; correspondence; test results; questionnaires/histories; photographs; videotapes; film/imaging; and records received by other medical providers.

☐ All physical therapist, occupational therapist, and speech/language therapists' evaluations; consultations; therapy logs; and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All pharmacy/prescription records, including NDC numbers and drug information handouts/monographs.

☐ Any and all educational records.

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☐ Educational records:

☐ Cumulative records	☐ Achievement and ability tests	☐ Special Education records
☐ Report cards and grades	☐ Transportation documents	☐ Work Samples
☐ Attendance records	☐ Speech/Language records	☐ 504 records
☐ Disciplinary records		

☐ Functional Behavior Assessments (FBAs) and Behavior Intervention Plans (BIPs)
☐ Medical/Nursing records and Individual Health Plans (IHPs) (including records provided by private providers)

☐ Other ____

If you would like any of the following sensitive information disclosed, check the applicable box(es):

☐ ***Alcohol/Drug Abuse Treatment/Referral***
☐ ***HIV/AIDS-related Treatment***
☐ ***Sexually Transmitted Diseases***

The protected information is disclosed for the following purpose _______________________________

____.

This release of information on behalf of ____ (student) is valid only for a period of one calendar year unless revoked in writing and provided to each party. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

I understand that this information will be handled in accordance with the receiving agency's confidentiality/privacy protection requirements. This release is exclusively authorizing Union County Public Schools to release the records specified herein to the agency/entity specified herein, and this release does not authorize the receiving agency to release the information to a third party.

I understand that I have the right to revoke this Authorization at any time by submitting written notice of the withdrawal of my consent to either the Exceptional Children's Department or the School, at the contact information listed above. I understand that the revocation will not apply to information that has already been released in response to, or in reliance upon, this Authorization. I recognize that these records, once received by the school district, will not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act.

Any facsimile, copy, or photocopy of the signed authorization shall authorize you to release the records described herein.

Signature of Patient/Authorized Representative (include relationship or nature of authority):

____ **Date**_______________________________
Signature of Parent/Guardian/Adult Student

____
Relationship