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

Student Name: _____ Date of Birth: _____

Information to be released by:
Physican/Agency/Persons _____
Address _____
Phone _____ Fax _____

Information to be released to:
School System: Union County Public Schools, North Carolina
School _____ Phone _____
Attention to: _____

I, _____, (parent/legal guardian/adult student) of _____ (student), hereby authorize and direct the disclosure of my/my child's information specified herein from the entities listed above, communicating orally and in writing, 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 disclose full and complete protected information, including the following:

☐ Unlimited disclosure

OR check all that apply:

☐ Vision testing/reports ☐ Health evaluations ☐ Immunization records
☐ Hearing/Audiological ☐ Social/developmental history ☐ ADHD/ADD reports
☐ Pharmacy/medication records ☐ Speech/Language records ☐ Physical therapy records
☐ Psychoeducational evaluations ☐ Medicaid/Medicare records ☐ Occupational therapy records
☐ Any and all educational records ☐ Medical evaluations/records*

*Medical records include but are 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.

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

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

Do you allow Union County Public Schools to release information to the individual/agency listed above? _____YES _____ NO

If you checked YES, complete this section. If you checked NO, move to the next section.

I, _____, (parent/legal guardian/adult student) of _____ (student), hereby authorize and direct the disclosure of my/my child's information specified herein to the entities listed above, communicating orally and in writing, 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 disclose full and complete protected information, including the following:

☐ Unlimited disclosure

OR check all that apply

☐ Cumulative records ☐ Achievement and ability tests ☐ Work samples
☐ Report cards and grades ☐ Transportation documents ☐ Special Education records
☐ Attendance records ☐ Disciplinary records ☐ 504 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 _____

Required

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 this information will be handled in accordance with the receiving agency's confidentiality/privacy protection requirements. 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 a written notice of the withdrawal of my consent to Union County Public Schools at the contact information listed above. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I recognize that medical 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.

_____ **Date**_____
Signature of Parent/Guardian/Adult Student

_____
Relationship