

**RANKIN COUNTY SCHOOL DISTRICT**  
**Authorization for Release of Health Information**



Completion of this document authorizes you to disclose and deliver individually identifiable health information including medical, psychological and/or other related records in your possession, including evaluations, assessments and/or \_\_\_\_\_ relating to the below-named patient. Completion also authorizes you to discuss this information with representatives of the organization named below entitled to receive said information.

**USE AND DISCLOSURE INFORMATION:**

Patient/Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

I, the undersigned, do hereby authorize \_\_\_\_\_ (name of agency and/or health care provider) to disclose and deliver the individually identifiable health information described for the named patient/student to:

RANKIN COUNTY SCHOOL DISTRICT  
SPECIAL EDUCATION DEPARTMENT  
ATTN: SHANNON BOYCE  
1220 APPLE PARK PLACE  
BRANDON, MS 39042  
601-825-5590 (phone), 601-824-2320 (fax)

**PURPOSE:**

This information is to be disclosed and used for the purpose of:

Special Education Evaluation & Planning       Other \_\_\_\_\_

**YOUR RIGHTS:**

I understand that I have the right to revoke this authorization in writing at anytime, and that the revocation will be effective upon delivery to the records custodian of the above entities, but will not apply to information that has already been released pursuant to this authorization. My authorization for the use or disclosure of the information identified above is voluntary and I also understand that I am entitled to a signed copy of this authorization.

**REDISCLASURE:**

I understand that the requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with the following individuals: special education administrative staff, including teachers, within the agency or institution has determined to have legitimate educational interests. If the disclosed information is not protected by FERPA, I understand that once it is disclosed, it may be redisclosed by the School District and the information may not be protected by federal privileges, privacy laws or regulations.

**APPROVAL:**

A copy of this release shall be as sufficient to authorize release of information identified above as the original signed by me. Unless sooner terminated in writing, this release shall remain effective for **one (1) year** from the date signed below. If the patient/student is under eighteen (18) years of age but is legally entitled to consent to treatment on his or her own behalf, the patient/student must sign this authorization.

\_\_\_\_\_  
Signature of Patient/Student OR  
Parent/Guardian of Patient/Student

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date