District one91

Future Ready. Community Strong.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Student Name (Last, First, Middle Initial) _____ School _____

Home Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone _____ Parent's Name _____

INFORMATION RELEASED FROM (Name of Staff Member or Department)	**INFORMATION RELEASED TO/EXCHANGED WITH** (Name of Staff Member or Department)
(Facility Name and Address)	(School Name and Address)
	Date Information Needed

PLEASE INDICATE THE INFORMATION TO BE DISCLOSED:

€ Discharge Summary € Emergency Record(s) € History and Physical € Psychiatric/Mental Health Records
€ Laboratory Report(s) € Operative Report € Radiology Report € Education Records
€ Chemical Dependency/Drug or Alcohol Abuse Treatment Records € Other (specify)_____
€ Verbal communication w/clinic staff re: medical condition and/or medication(s)/treatment(s)/procedure(s) used to treat condition

Approximate Visit Dates:_____

This information is to be released for the purpose of: _____

Authorization expiration date or event: _____(if left blank, will expire one year from date of signature)

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. **A photocopy/fax of this authorization will be treated in the same manner as an original.**

It is understood that this information will be kept private and will be used in the best educational interest of the student. Further, I realize that ISD #191 cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, ISD #191 is released from any and all liability resulting from redisclosure. I understand that I may refuse to complete this form. The consequence for refusal may result in the district not receiving needed medical information and/or documentation and, as a result, my child may not receive necessary medical or educational services. I have read and understand my rights as described on this form.

_____ _____ _____

Parent/Legal Representative Signature Date Authority to act on behalf of student (attach document)