FINAL 11/06

STATE OF LOUISIANA

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

PART 1: CONTACT INFORMATION

Student's/Child's Legal Name	Date of Birth	Social Security #

Parent/Legal Guardian _____ Telephone # _____

Mailing Address _____

PART 2: RECORD REQUEST

Complete box A **OR** box B below. Both boxes may not be completed on the same form.

A. Specify the records to be released for the treatment date(s) listed below in Part 3:

- ❑ COMPLETE RECORD(S)
- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Operative Report
- ❑ Consultation
- ❑ Progress Notes
- ❑ Cardiopulmonary **(Indicate EKG, Stress Test, Sleep Study)**
- ❑ Emergency Room
- ❑ Lab
- ❑ Pathology
- ❑ Radiology Results
- ☒ Other Medical documentation and medication list

B. If initialed below, I specifically authorize release of the following:

Psychotherapy notes and records indicating psychological or psychiatric impairment(s)

_____
Initials of parent/legal guardian

PART 3: AUTHORIZATION

This does not authorize the release of the following: drug and alcohol use counseling and treatment and HIV/AIDS and sexually transmitted disease testing and treatment.

I authorize:

Name: TANGIPAHOA PARISH SCHOOL SYSTEM (School System)

☒ **TO RELEASE Information TO** **AND/OR** ☒ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released AND/OR requested.)

Name: _____ (Hospital, Physician, Service Agency, School RN and/or other health provider)

For treatment date(s): _____

The information is to be released for the purpose(s) of:

- ☒ Evaluation to determine eligibility or continued eligibility for special education services
- ❑ Providing physical therapy treatment
- ❑ Providing occupational therapy treatment
- ☒ Designing an individual educational program
- ☒ Determining appropriate placement for treatment needs
- ❑ _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the same medical records department receiving this authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in nine (9) months from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability & Accountability Act of 1996.

_____ _____ _____
Signature of Student or Legal Representative (Parent/Legal Guardian must sign if student < 18) | Date | (Relationship to student)

_____ _____
Signature of Witness | Date