Durham • Freeport • Pownal

Student Name: _____
Student DOB: _____

Authorization to Release/Exchange Information

This release must be filled out completely. Please Read Carefully.

I hereby authorize RSU 5 to:

- ☐ Release Medical/Educational/Psychological Records to: _____
- ☐ Obtain Medical/Educational/Psychological Records from: _____
- ☐ Discuss with: _____
- ☐ Both release Medical/Educational/Psychological Records and to discuss with: _____

Name: _____ Address: _____ City: _____ State/Zip: _____

The following information:

- ☐ All information, including history, dates, course of treatment or interventions and any evaluations (indicate approximate dates)
- ☐ Only the following information: _____

1.	I Do	I Do Not	authorize disclosure of information which refers to treatment or diagnosis of Drug or alcohol abuse. If I authorize the release of such information, I understand that it cannot be re-disclosed by recipient without specific consent and cannot be used against me in a criminal proceeding.
2.	I Do	I Do Not	authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.
3.	I Do	I Do Not	understand that I have the right to review this information at any reasonable time, including prior to its release. Review must be supervised by a member of the RSU 5 Instructional Support Team.
4.	I Do	I Do Not	authorize disclosure of information which refers to treatment or diagnosis of HIV infection, ARCS, or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance and family and social relationships.

For Purpose of:

- ☐ Ongoing educational programming and/or instructional support evaluation
- ☐ To coordinate with treatment of efforts with family/concerned others
- ☐ At the request of the individual/patient
- ☐ Other (specify) _____

I Understand That:

- I can refuse to disclose some or all of the information in my treatment records, but this may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.
- I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated, and signed letter to RSU 5.
- I am entitled to a copy of this EVALUATION upon request.

This authorization is effective until _____(or six months from the date below if I do not specify a date) and I authorize future disclosures regarding these records to the same individual and/or entities during this time period.

_____	_____	_____
Signature of Parent/Guardian	Printed Name	Date
_____	_____	_____
Signature of Student (if applicable)	Printed Name	Date
_____		
Witness		

Regional School Unit No. 5
17 West St., Freeport, ME 04032 Telephone: 865-0928