



**AUTHORIZATION TO DISCLOSE AND RELEASE HEALTH INFORMATION  
TO/ FROM RICHLAND COUNTY SCHOOL DISTRICT TWO**

**Student's Full Name** \_\_\_\_\_ **Student's DOB** \_\_\_\_\_

I hereby request and authorize the **provider(s) named below to disclose** any/all of my child's verbal and/or written Medical records, Educational records, Psychological records, and other relevant information, including personal health information, to Richland County School District Two for purposes of their involvement in my child's education, healthcare, support services, and/or payment related to healthcare services.

**Provider(s)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize **Richland County School District Two to disclose** any/all of my child's verbal and/or written Medical records, Educational records, Psychological records, and other relevant information, including personal health information, to the following providers for purposes of their involvement in my child's education, healthcare, support services, and/or payment related to healthcare services

**Provider(s)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**By signing this authorization, I acknowledge that:**

1. The person(s) and categories of persons identified above may not be covered by federal privacy regulations, and thus, the health information, Medical records, Educational records, and Psychological records and other relevant information released might be re-disclosed and not protected by applicable federal laws.
2. I may refuse to sign this authorization and my refusal to sign will not affect my ability to work with school personnel.
3. I may submit to the healthcare provider a written request for an accounting of disclosures made pursuant to this authorization;
4. I may revoke this authorization, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization;
5. Unless revoked earlier, this authorization will expire at the end of the school year in which the authorization was signed. A new authorization will be needed to release information the following school year.
6. I have received a copy of this Authorization form.

\_\_\_\_\_  
**Parent or Guardian Signature (Student's signature if 18+)**

\_\_\_\_\_  
**Date**

**Please mail or fax the above names student's records to: Requested by:**

School: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Fax: \_\_\_\_\_  
Attention: \_\_\_\_\_

Signature: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Phone: \_\_\_\_\_