



BSD

BELGRADE SCHOOL DISTRICT #44
312 N. Weaver, P.O. Box 166, Belgrade, MT 59714

PERMISSION TO OBTAIN AND RELEASE INFORMATION

_ Name: Last, First, Middle Date of Birth Phone

_ Street Address City State ZIP

Authorize Records Released To and From: Records Released To and From:

Name Name

Street Address Street Address

State ZIP City State ZIP

City

Type or extent of information to be released: (Check all applicable categories)

Medical and/or related health records Laboratory reports
 Psychological evaluations or social work reports Consultations
 Developmental/Learning Disability Evaluations and related reports Individualized education program Other _____

Purpose or need for release: _____

This authorization will remain in effect until: _____ **or for one year from date signed,**
Date

and WILL or WILL NOT apply towards records created after the date of signature.

I understand that information used or disclosed based on this authorization may possibly be redisclosed by the recipient, and/or no longer protected by Federal Privacy standards. I understand that if I agree to sign this authorization, I will be provided with a copy of it. I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision not to sign this authorization. I understand written notification is necessary to cancel this authorization. I am also aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that have already been made in reference to this authorization.

Patient (including minors 14 and over) Date Signature of
(If signed by person other than patient, state relationship to patient)

Signature of parent or guardian