Northridge Local School District
6097 Johnstown-Utica Road
Johnstown, Ohio 43031

Authorization for Release/Exchange of Information

Student Name: (First, M.I., Last)	Date of Birth: (mm/dd/yy)
Name of Person Completing this Form:	Relationship to Student: ☐ Child/Self ☐ Parent ☐ Guardian ☐ Other:

Grants Consent and Authorizes:

Northridge Local Schools 6067 Northridge Road Johnstown, Ohio 43031 Phone: 740-967-6631 Fax: 740-967-5022	To: ☐ Release to ☐ Receive from ☐ Both (Release/Recieve)	Identified Party: (Organization, Individual) ____________________ Contact Information: (Phone, Fax, Address) ____________________

In the following format/s: ☐ Verbal ☐ Written ☐ Both

I authorize the following information to be released:
☐ Medication List ☐ Progress Notes ☐ Treatment Goals ☐ Summary of Care
☐ Nursing Notes ☐ Diagnoses ☐ Other: (Specify) ________________________________

During the following dates/times:
☐ Most Recent Admission ☐ Past Three Months(Quarter/Nine Weeks) ☐ All
☐ From ______ to ______ ☐ Other (Specify): ________________________________

Purpose of Disclosure:
☐ Continuity of Care ☐ Legal ☐ Educational ☐ Other (Specify): ________________

Any exceptions/exemptions to information being released: ____

I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that the action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire upon the completion of the treatment, unless I specify a date or event stated below. Expiration date or event:____

My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services. If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation. Records released pursuant to this authorization request may include information regarding testing, diagnosis, or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.

____ ____________________
Signature Date

If this authorization has been completed by a personal representative or guardian on behalf of an individual, their authority to act on behalf of the individual must be set forth here:

______________________________ ____________________ ______________
Signature Relationship Date

____ ____________________
Staff Signature Date