AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, do hereby request and authorize the
(Name of parent, guardian, student if 18 years of age)

Falmouth Public Schools ☐ to release to, ☐ obtain from, and/or ☐ discuss with

____
(Name and address of agency, physician, or hospital)

Information regarding ____ (_____/_____/_____)
(Student name) (student date of birth)

For purpose of:

☐ Educational Planning ☐ Ongoing Treatment/Aftercare ☐ To coordinate treatment efforts

☐ Other (please specify): ____

This information may include:

☐ Special Education Records	☐ Progress Notes	☐ Medical	☐ Consultations
☐ Complete Record	☐ Psychiatric Evaluation	☐ Treatment Plan	☐ Intake Evaluation
☐ Diagnostic Tests	☐ Discharge Summary	☐ Other Records: ____________________	

I DO authorize the 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 a recipient without my specific consent.	I DO NOT: ____________ (Initial here)
I DO authorize the disclosure of information which refers to treatment or diagnosis of **HIV** infection or **AIDS.**	I DO NOT: __________ (Initial here)
I DO authorize disclosure of information which refers to treatment or diagnosis of **MENTAL HEALTH**	I DO NOT: ____________ (Initial here)
If I authorize the release of Mental Health, **I DO NOT** want to review the information before it is released.	I DO: _______ (Initial here) I understand that such review must be supervised.

- ❖ This consent has been made freely, voluntarily, and without coercion.
- ❖ I was able to ask questions and receive answers about this release.
- ❖ I hereby authorize releasing/obtaining of the information as specified above and further understand that those who receive this information cannot disclose it to others without my further consent, unless permitted by Federal or State Law.
- ❖ I understand that I may revoke this authorization at any time.
- ❖ This authorization is effective for a period of one year from the date of signing.
- ❖ This release is valid only for the purpose stated. Falmouth Public Schools must obtain my written authorization before releasing any further information to any other agency.

I do hereby release Falmouth Public Schools and this agency/physician from all liability and all claims pertaining to the disclosure of this information when used as authorised.

____ ______________________
Signature of parent, guardian or student (18 years of age) Date

____ ______________________
Printed Name of authorized representative Date

____ ______________________
Witness Date