DUNELAND SCHOOL CORPORATION
601 W Morgan Avenue; Chesterton, In 46304
219-983-3600 fax 219-983-3614

Student/ Patient Name:_____ Date of Birth:_____

☐ Send from: ☐ Send to:	☐ Send from: ☐ Send to:
Duneland School Corporation **(and its affiliates, employees and agents)** **601 W Morgan Avenue Chesterton, In 46304** **219-983-3600 fax 219-983-3614** Attn: (name and title): _____	Agency: _____ (and its affiliates, employees and agents) Address: _____ City/State: _____ Phone number: _____ Fax number: _____ Attn: (name and title) _____

A. Information to be disclosed:

Typical **School** Information)

☐ Transcripts, report cards, attendance reports
☐ School Health Records
☐ RTI Data/General Education Referral
☐ Specialized/Diagnostic Evaluation
☐ Special Education Records/Psychological Evaluation
☐ Discipline and Behavior Records
☐ Other _____
_____

(Specific Mental Health/Health Agency Information to be released)

☐ Entire medical record including all of below:
☐ Medical History/Hospitalization
☐ Summary of Psychiatric Treatment
☐ Medication History
☐ Psychiatric Evaluation Results
☐ Mental Disorder/Diagnosis
☐ Most Recent Contact Date
☐ Drug and Alcohol Information
☐ Treatment Plan
☐ Clinician's Office Notes
☐ Patient Histories
☐ Test Results
☐ Records sent to you by other health care providers

By signing here, _____, I give specific authorization to disclose the following:

☐ HIV test results ☐ Drug and alcohol abuse treatment records ☐ Psychotherapy notes
☐ Documentation of AIDS diagnosis ☐ Psychiatric/Mental health treatment records

B. Purpose of Disclosure:

☐ At the request of the individual or ☐ Other:_____
_____

C. Authorization to Discuss Health Information

☐ By initialing here _____ (Initial) I authorize _____ (Name of individual health care provider) to discuss my health information with the School listed here:

_____
(Name of individual or school entity)

D. Authorization Statements:

- I understand that I am not required to sign this authorization but I further understand that failure to grant authorization for the requested information may limit the school's ability to determine eligibility for services and/or develop an appropriate education plan for the student.
- I understand that the records for which I am authorizing release, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become educational records protected by the Family Educational Rights and Privacy Act. As educational records, they may be subject to re-disclosure.
- I understand that this authorization is valid from the date of my/my representative's signature below and shall expire one year from that date, unless I revoke this authorization in writing.
- I understand that I may withdraw or revoke my permission at any time by writing to the Superintendent of Duneland School Corporation, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I further understand that I am entitled to receive a copy of this authorization, if requested, and that a photocopy of this authorization is as valid as the original.
- I release the individuals and/or organization named in this authorization from legal responsibility or liability for the disclosure of the records authorized on this form.

_____ _____
Signature of Adult Consenting to Release (Either Employee or Parent) Date

_____ _____
Student Signature (if aged 12 or older) Date