WEST FARGO PUBLIC SCHOOLS

AUTHORIZATION & CONSENT TO RELEASE INFORMATION

Name of Student: (Last, First, Middle Initial):			Date of Birth:
Street Address:	City:	State:	Zip Code:

I, the undersigned herby request and authorize **West Fargo Public Schools staff** to discuss or release and/or collect relevant information through written and/or verbal communication of the student named above to:

Name of Person/Organization: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

The following Information is requested: ***(check all that apply)***

- ☐ Educational Records
- ☐ Medical Records
- ☐ Addiction Evaluations/ Progress Reports/Treatment Plans & Recommendations
- ☐ Mental Health Assessments, treatment goals, outcomes, progress reports, diagnosis, and recommendations
- ☐ Legal Status/Court Orders
- ☐ Other: _____
- ☐ Other: _____

This authorization to disclose information remains in effect until: ***(list date)*** _____

This information will be used for: _____

CONSENT: *This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written* notice to the agency or person. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits except as permitted by law.
Health Information Directive: I authorize the use and disclosure of my individually identifiable health information as described above, and I understand that if the person or organization I authorize to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

Signature of Student: ***(if 18 years of age or older)***	Date:
Signature of Parent/Guardian or Custodian, and Relationship:	Date:
Signature of Witness *(if needed):*	Date:

☐ **CHECK IF APPLICABLE-NOTICE, TO WHOMEVER DISCLOSURE IS MADE, CONCERNING ADDICTION RECORDS**
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 42CFR Part 2, information disclosed to another entity may potentially be re-disclosed, in which case it may not be protected by state or federal law.

DISTRIBUTION: ☐ To Agency/person from whom information is sought ☐ Requesting Agency/Parent/Guardian