Authorization to Release Information

Print Form

Health Services
Mat-Su Borough School District
501 N. Gulkana
Palmer, AK 99645
P: (907) 746-9200 || F: (907) 761-4089

Student Name:_____ Birth Date:_____ Phone Number:_____

I authorize: (Where information is stored)
Name:_____
_____
Address:_____
_____
Phone:_____
Fax:_____

To release to:(where information should be sent)
Matanuska-Susitna Borough School District
Name (s) _____
_____
_____
Phone:_____
Fax:_____

Specific dates of service or conditions to be released: _____

Information being requested: (Please check appropriate boxes)

- ☐ Verbal exchange of information
- ☐ Immunization Records
- ☐ Psychological/Educational notes & testing
- ☐ Laboratory/Radiology Reports
- ☐ Admission/Discharge Summaries
- ☐ Complete Medical/Educational Records
- ☐ History and Physical
- ☐ Disciplinary Reports
- ☐ Individual Educational Plans School
- ☐ Observations and Ratings
- ☐ Treatment Plan
- ☐ Other _____

I acknowledge that the information to be released **MAY INCLUDE** material that is protected by Federal Law. **My initials and signature** below authorize release of the following type of information:

_____ Mental Health, if any _____ Drug abuse, if any (with signature of minor required by law)

The purpose of the receipt, use or disclosure of this information is:

_____ As needed for guidance and education planning during treatment and upon return to school
_____ To determine immunization status of student
_____ Other: _____

I hereby authorize the use or disclosure of health care and/or other information as described above. I understand that this authorization is voluntary. I understand that records may contain sensitive information. I understand that I may revoke this authorization at any time by notifying the individual (s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual (s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I provide this authorization. I understand that if the person (s) organization authorized to receive this information is not a health plan or health care provider, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization. I understand that once the school receives these records, the information will become part of the student's education record and will move with the student.
This authorization expires on the following date _____ or event: _____

Means of Delivery: _____Pick-up, _____Mail, _____Fax, _____Personal Delivery

Parent/Legal Guardian Signature _____ Relationship_____

Date signed_____

Student Signature: _____
(Minor's signature required if information contains information pertaining to drug abuse)

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as other wise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party 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.

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A PHOTOCOPY OF THIS AUTHORIZATION IS VALID AS THE ORIGINAL

Matanuska-Susitna Borough School District
REVOCATION SECTION

I request that the authorization to release information of:_____
(Printed Name of Student/Patient)

Described on the form dated_____, be rescinded, effective_____. I
(Date)

Understand that any action taken on this authorization prior to the rescinded date is legal and binding and we can not be used in any manner against the Matanuska-Susitna Borough School District or its employees or agents.

_____ _____
Signature of Student/Patient or Parent/Guardian Date

_____ _____
Printed Name of Student/Patient or Parent/ Guardian Relationship to Student/Patient

_____ _____
Signature of School District Employee Date

_____ _____
Printed Name of School District Employee Job Title