MEDICAL/EDUCATIONAL INFORMATION REQUEST GWINNETT COUNTY PUBLIC SCHOOLS

____
Student's Name   Birthdate

____
Address   Telephone

____
School   Services Provided

_____I hereby authorize a release of information as identified between Gwinnett County Public School Staff and the individual(s) indicated below concerning the above named student.

____Pediatrician
____Neurologist
____Orthopedist
____Pulmonologist
____Rheumatologist
____Gastroenterologist
____Psychologist
____Educational Consultant
____Occupational Therapist
____Urologist
____Speech-Language Pathologist
____Other__________________

Releasing doctor/clinic information:

NAME______________________________
ADDRESS___________________________
ZIP ______________________________
PHONE_____________________________
FAX ______________________________

Types of Records Needed:

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____
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The above records are for the purpose of educational planning.

- I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug or psychiatric disorders.
- I authorize the inspection of the above information by the above names agency/person and/or to the furnishing of a photostat or other copies.
- I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information disclosed prior to Gwinnett County Public School System receiving a written notice of withdrawal.
- I hereby release Gwinnett County Public School System and its officers, directors, agents, and employees from any and all liabilities, responsibilities, damages, losses, and claims which might arise from the release of the information authorized above.
- In furtherance of this authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.
- I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily authorize the disclosure of this medical information to the individual or agency named above.

In compliance with the Family Educational Rights and Privacy Act of 1974, these records will be released to Parents/Guardians or Students over 18 years of age upon their request. The granting of consent is voluntary on the part of the parent.
This authorization expires_________________________(insert applicable date or event or insert "no expiration designated") or 12 months for school requests whichever is shorter, and no further use/disclosures as described above may be made after the expiration. Authorizations apply only for medical records for specified treatment dates prior to and on the date of signature, unless otherwise specified. Specified exceptions for future-dated releases are: ____

Signature:_______________________________ Date:_______________________________
Parent or Guardian

Rev. 07/28/14