AUTHORIZATION FOR THE DISCLOSURE OF STUDENT'S EDUCATIONAL RECORDS TO HEALTH PROVIDERS

I hereby request and authorize that the Guilford County Schools disclose the following records and/or information to the below listed health/mental health providers and waive any protections that the Family Educational Rights and Privacy Act ("FERPA") or other laws regarding confidentiality provide regarding the production of these records for this limited purpose of permitting them to be produced to the listed medical/mental health care services which provide to the Patient any type of health care ("Provider" or "Providers"). I am authorized to permit disclosure, as indicated below:

Patient. Patient Name: _____, Birth Date: _____

Authorized Information. The information to be disclosed and/or discussed ("Authorized Information") is:

_____Unlimited Disclosure	____Vision, Testing Results	_____ADHD Reports
_____Social Developmental History	____Exceptional Children's Service Records	_____Speech/Language Testing
_____Hearing/Audiological	____Records pertaining to Behavioral Incidents	
_____Current Medications	____Educational Records	Other_____

Unlimited Disclosure means any and all information and records related to the Patient, including any and all such information that relates to the past, present, or future education or physical or mental health or condition of the Patient; the provision of educational services to the Patient, and including such information in any form, ***whether paper hard copy, electronic copy, verbal communication, or other***.

Party Receiving the Disclosure: Providers are requested and authorized to disclose and discuss Authorized Information to and with the party listed below ***if and whenever the party may request Authorized Information for any reason whatsoever***:

Providers for the Patient:

I also authorize the Providers and representatives of GCS to discuss the patient and the patient's records by telephone or in person and to share copies of relevant records as appropriate.

Purpose of Disclosure. For matter's concerning, relating to, or arising out of school activities of the Patient.

Expiration. This authorization expires on _____ unless validly revoked prior to that date.

Additional Matters. I understand that:

- This authorization includes any Authorized Information that concerns a communicable disease or condition (including HIV, AIDS, AIDS-related conditions, and sexually transmitted disease), drug or alcohol abuse, or mental illness, developmental disability, or substance abuse (including information governed by G.S. 130A-134, G.S. 122C-52, or 42 CFR, Part 2).
- The authorization extends to Authorized Information that Provider obtained from other sources.
- The potential exists that the Authorized Information disclosed might be re-disclosed by the recipient and also might be no longer protected by law, including by federal privacy laws.
- Provider may not condition treatment of the Patient on whether I sign this authorization, and I may refuse to sign this authorization.
- Authorized Information does not include "psychotherapy notes" as that term is defined by HIPAA.
- I may revoke this authorization in writing at any time except to the extent that a Provider has already taken action in reliance on this authorization. A revocation must be actually delivered to a Provider to be effective.

I voluntarily and knowingly execute this Authorization, understanding that I have all authority not to execute it if I so desire.

_____ _____
Signature of Patient's Personal Representative Date:

_____
Representative's Printed Name

_____
Description of Representative's Authority to Act for Patient