

Authorization to Use and Disclose Health/Service Information Release of Information (ROI) Form

Student	Student Name: _____ Birth Date: _____ _____														
Released By	I authorize: This/these entity(ies) (name/address of recipient(s)): Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student														
Released To	I authorize: This/these entity(ies) (name/address of recipient(s)): Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student														
Purpose	For the purpose(s) of: <input type="checkbox"/> This information may be used or disclosed in connection with mental health treatment/services and healthcare operations. <input type="checkbox"/> Other purposes (specify each purpose): _____ _____														
Information to be Disclosed	Description or nature of information to be used and/or disclosed: (check all that apply) <input type="checkbox"/> Assessment/Intake Summary <input type="checkbox"/> Psychiatric Reports <input type="checkbox"/> Service/Treatment Plan <input type="checkbox"/> Progress Report <input type="checkbox"/> Safety/Crisis Plan <input type="checkbox"/> Other records(specify): _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 5px;"> Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </td> <td style="padding: 5px;"> My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released. </td> </tr> <tr> <td style="padding: 5px;"> Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </td> <td style="padding: 5px;"> My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released. </td> </tr> </table>	Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released.	Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released.										
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Notices	I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information. I understand that I may revoke this authorization in writing at any time.														
Expiration	I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Unless sooner revoked, this authorization is valid for 180 days from the signature date below, or for the following time period: Date: _____														
Signatures	I have read this authorization, I understand it and I have been offered a copy. A minor patient's signature is required in order to release the following information: (1) HIV/AIDS status, diagnosis, treatment 14 years of age; (2) family planning/abortion no age limit; (3) alcohol/drug treatment 13 years of age; and (4) mental health services 13 years of age. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; border-bottom: 1px solid black; text-align: center;">Signature of student</td> <td style="width: 20%; border-bottom: 1px solid black; text-align: center;">Date</td> <td style="width: 40%;"></td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Signature of legal/personal representative</td> <td style="border-bottom: 1px solid black; text-align: center;">Relationship to student</td> <td style="border-bottom: 1px solid black; text-align: center;">Date</td> </tr> </table> <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 25%; background-color: #cccccc;">Update of Authorization</td> <td style="width: 45%;">Signature 1: _____</td> <td style="width: 10%;">Date: _____</td> <td style="width: 20%;"></td> </tr> <tr> <td></td> <td>Signature 2: _____</td> <td>Date: _____</td> <td></td> </tr> </table>	Signature of student	Date		Signature of legal/personal representative	Relationship to student	Date	Update of Authorization	Signature 1: _____	Date: _____			Signature 2: _____	Date: _____	
Signature of student	Date														
Signature of legal/personal representative	Relationship to student	Date													
Update of Authorization	Signature 1: _____	Date: _____													
	Signature 2: _____	Date: _____													



AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____
School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Diagnosis: _____

<u>Name of Medication</u>	<u>Dosage</u>	<u>Methods of Administration</u>	<u>Time of Day to be Taken</u>

If given PRN, specify the length of time between doses.

Student is capable to self-administer medication: Yes No
If a health professional and a student's parent request that a student be permitted to carry his or her own medication and/or be permitted to self-administer the medication, the principal may grant permission after consulting with the school nurse.

Possible side effect of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above-named student be administered the above-identified oral medication in accordance with the instructions indicated above from _____ to _____ (do not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Health Care Provider Signature _____ Date _____

Health Care Provider (Type or Print) _____ Telephone Number _____

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Parent/Guardian Signature _____ Date _____

Parent/Guardian (Type or Print) _____ Telephone Number _____