Osseo Area Schools

AUTHORIZATION TO RELEASE/OBTAIN PRIVATE DATA

School _____ Address _____ School Phone # _____

A. Student/Patient Name: _____ Grade: _____ Date of Birth: _____

Address: _____

Parent Name (if student is under 18 years old): _____

B. I authorize _____

Name, Title *Name of Organization*

_____

Address *Phone Number* *Fax Number*

C. Purpose: To coordinate services and assist in the student's educational planning (check one or both):

◯ to release written and verbal information to and/or ◯ to obtain written and verbal information from

Check both boxes if consenting to two-way conversation/written health information

_____

Name, Title, Worksite of School Representative *Phone Number* *Fax Number*

D. Indicate only the information that you are authorizing to be released:

1. □ Specific Dates of Treatment _____
   a. □ Mental Health Assessment/Diagnosis
   b. □ Care Plan
   c. □ Medical Reports
   d. □ Chemical Abuse/Dependency Report (student consent needed if student is 18 years of older)
   e. □ Educational Records (including Special Education Records)
   f. □ Counseling Report
   g. □ Social Work Report
2. □ Ongoing exchange of health information
3. □ Other (*specify*) _____
4. □ Other (*specify*) _____

- I understand that by signing this form, I am requesting that the health information specified above be sent to the organization I have named above.
- I understand that the laws that protect the information identified on this release, in some situations, may allow or require this entity to re-disclose information, but only as permitted by law, according to the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and Minnesota Government Data Privacy Act (MGDPA), Minnesota Statutes Chapter 13, and may no longer be protected by any federal or state laws.
- I understand that if the organization above is a health care provider, they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this form.
- I understand that this consent takes effect the day that I sign it. My consent applied only to information available on the date of my signature unless I checked Section D2 above (the authorization for ongoing discussion of my health information).
- I understand that by signing this consent that upon request, the district will provide a copy of the records disclosed to me as the parent/guardian/adult student.
- I may change this consent or authorization at any time by sending a written notice of the change to the releasing school.
- If I do not change this consent or authorization, it will expire one year from the date of my signature.

_____

Parent/Guardian or Adult Student Signature *Date*