OFFICIAL RELEASE OF CONFIDENTIAL RECORD INFORMATION

Great Falls Public Schools
P.O. Box 2429
Great Falls, MT 59403
406-268-6000

Date: _____

Student Name: _____ Birth Date: _____

To: (i.e. doctor's name, school name)

_____

_____

_____

Please send information to: (GFPS School/Department)

_____

_____

_____

☐ **I authorize the released information to be exchanged with** _____
(Name of Primary Care Physician)

I hereby authorize the above-mentioned agency/school or individual to (check all the apply):

☐ Release Information to GFPS
☐ Obtain Information from GFPS
☐ Exchange Information with GFPS

Dates of Service: _____ TO _____

The information to be released (check all that apply):

☐ Official School Records (including Special Education records and health records)
☐ Medical
☐ Speech/Language/Audiological
☐ Psychological
☐ Teacher, Counselor, Staff Observations, and Impressions
☐ Homebound Verification
☐ Life Threat Assessment
☐ Legal
_____ *(Initials)* Psychotherapy Nurse
_____ *(Initials)* HIV/AIDS Diagnosis

Reason for Requesting Information: _____

AUTHORIZATION

This authorization is valid for one calendar year. It will expire _____ (Insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records once received by the school district, may not be protected by the HIPAA Privacy Act. I also understand that the facility where the records are acquired may not condition the provision of treatment, payment or enrollment in a health plan or eligibility for benefits on my failure to provide an authorization of release of my child's health information except as limited by that facilities condition under the HIPPA Privacy Act.

_____ _____
Signature Parent/Guardian/Surrogate/Adult Student Date

☐ If no records are available, please check box and return this form with explanation:

_____
_____
_____
_____