

**FOR APPLICANTS WHO ARE CURRENTLY ATTENDING SCHOOL OUTSIDE OF  
CHERRY CREEK SCHOOL DISTRICT ONLY**

**CHERRY CREEK SCHOOL DISTRICT #5  
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, (Parent or Authorized Personal Representative) authorize the release of protected health and medical information as described in this authorization.

**STUDENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

- 1) I request the following information to be exchanged between Cherry Creek School District #5/ Office of Gifted & Talented Services and the organization/agency below:

| <b>FROM/TO:</b>        | <b>TO/FROM:</b>                                                                 |
|------------------------|---------------------------------------------------------------------------------|
| Agency/Unit _____      | Cherry Creek School District #5/Office of<br>Gifted & Talented Services         |
| Address _____          | Address 14188 E Briarwood Ave                                                   |
| City, State, Zip _____ | City, State, Zip Centennial, CO 80112                                           |
| Phone/FAX _____        | Email: <a href="mailto:gt@cherrycreekschools.org">gt@cherrycreekschools.org</a> |
| Attention: _____       | Attention: <u>Alison Renova</u> Phone: <u>720-886-7050</u>                      |

**WRITTEN RECORDS TO BE RELEASED OR SECURED:**

- |                                                                              |                                                                          |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Admission/Discharge Summary                         | <input checked="" type="checkbox"/> Special Education Records            |
| <input checked="" type="checkbox"/> Psychiatric Evaluation                   | <input checked="" type="checkbox"/> Speech/Language Evaluation           |
| <input checked="" type="checkbox"/> Psychological Evaluation                 | <input checked="" type="checkbox"/> Occupational/Physical Therapy Report |
| <input checked="" type="checkbox"/> Social History                           | <input checked="" type="checkbox"/> Educational Evaluation               |
| <input type="checkbox"/> Family Systems Evaluation                           | <input type="checkbox"/> Course Transcript (clock hours & grades)        |
| <input type="checkbox"/> Medical History/Physical Exam                       | <input type="checkbox"/> Social Service Records                          |
| <input type="checkbox"/> Legal Information                                   | <input type="checkbox"/> Supervision Plans                               |
| <input checked="" type="checkbox"/> <u>Other Gifted and Talented Records</u> | <input type="checkbox"/> Substance Abuse Records                         |

**I authorize:**

- ☐ Phone contact to share information
  - ☐ Attendance by individuals at planning meetings
- 2) I authorize the information to be disclosed to appropriate school officials within Cherry Creek School District #5 who have a need to receive this information in order to fulfill their duties and responsibilities associated with the education and mental health treatment of the student.
- 3) Right of Revocation: I understand this authorization will expire annually, without my express revocation upon \_\_\_\_\_ (enter date one year from today). I understand that I may revoke this authorization at any time upon written notice except to the extent that action has already been taken based on this authorization. I further understand that the revocation is only effective after it is received and logged by Cherry Creek School District #5. Further, I have a right to a copy of this authorization.
- 4) Re-disclosure: I understand that authorization for the disclosure of this health information is voluntary, and I can refuse to sign this authorization. Treatment, payment, enrollment in the health plan or eligibility disclosure of information carries with it the potential for re-disclosure, and once the information is disclosed, it may no longer be protected by federal HIPAA confidentiality rules.
- 5) All information received and maintained by Cherry Creek School District #5 will be kept confidential pursuant to the Family Education Rights and Privacy Act 20 USC1232(g) ("FERPA") and Policy JRC.

\_\_\_\_\_  
Signature of Parent/Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Guardian/Personal Representative (Print) and Relationship