

OFFICIAL RELEASE OF CONFIDENTIAL INFORMATION

Date: _____

Student Name: _____

Birth Date: _____

To:

Please send information to: (GFPS)

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

Reason for requesting information: _____

I hereby authorize the above-mentioned agency or individual to (check all that 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)

- | | |
|---|---|
| <input type="checkbox"/> Official School Records (including Special Education records and health records) | <input type="checkbox"/> Homebound Verification |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Life Threat Assessment |
| <input type="checkbox"/> Speech/Language/Audiological | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Psychological | _____(Initials) Psychotherapy Notes |
| <input type="checkbox"/> Teacher, Counselor, Staff Observations and Impressions. | _____(Initials) HIV/AIDS Diagnosis |

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 protected health information except as limited by that facilities condition under the HIPAA Privacy Act. I understand that revocation is not possible once disclosure has been released.

Signature Parent/Guardian/Surrogate/Adult Student

Date

If no records are available, please check here and return this form.