No Facsimiles Will Be Accepted for Release of Medical Information

OMSD SPECIAL EDUCATION LOCAL PLAN AREA
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Name of student (list other names used) | *Medical Record Number (if applicable)* | *Date of Birth*

Address of student | *Phone No.* | *Other Phone No.*

I authorize the following individual or organization to exchange the above named individual's medical/educational information as described below:

Individual or Organization:	**Individual or Organization:**
Address *City, State, Zip Code* *Telephone:* _____ *FAX:* _____ Not valid for medical information	*Address* *City, State, Zip Code* *Telephone:* _____ *FAX:* _____ Not valid for medical information

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (*date)* or for one year from the date of signature if no date is entered.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

Redisclosure: I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

Health Info: I understand that authorizing the disclosure of health information is voluntary.

Specify Record(s): Indicate type of information is to be disclosed:

☐ **Medical** ☐ **Medication** ☐ **Psychiatric** ☐ **Mental Health**

☐ **Drug/Alcohol** ☐ **Educational** ☐ **Other:** _____

Any and all information with regard to the above records may be released except as specifically provided here:

_____

I request that the information released pursuant to this authorization be used for the following purposes only:

☐ **Educational Assessment** ☐ **Educational Planning** ☐ **Other:** _____

A copy of this authorization is as valid as an original.
I understand that I have a right to receive a copy of this authorization for my records.

Signature of Student/Student's Representative | *Description of Relationship to Student* | *Date*