ANCHORAGE SCHOOL DISTRICT
REQUEST FOR RELEASE OF HEALTH INFORMATION

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICAL PROVIDERS AND SCHOOL DISTRICT

Completion of this document authorizes you to disclose and deliver individually identifiable health information including medical, psychological and/or other related records in your possession, including evaluations, assessments and/or ____________________ relating to the below-named patient. Completion also authorizes you to discuss this information with representatives of the organization named below entitled to receive said information.

The following types of records would not be released unless checked (*please check boxes*):

☐ drug/alcohol treatment ☐ mental health treatment ☐ HIV/STD status

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: ____________________ Date of Birth: ____________

Social Security Number: ____________________

I, the undersigned, do hereby authorize ______________________________

(*name of agency and/or health care provider*)

to disclose and deliver the individually identifiable health information described for the named patient/student to:

Name: ____________________ Organization: ____________________

Address: ____

City/State/Zip Code: ________________ Telephone Number: ______________

PURPOSE:

This information is to be disclosed and used for the purpose of:

☐ Special Education Evaluation & Planning ☐ § 504 Evaluation & Planning

☐ Information for School Nursing ☐ Other ______________ (*please provide explanation*).

YOUR RIGHTS:

I understand that I have the right to revoke this authorization in writing at anytime, and that the revocation will be effective upon delivery to the records custodian of the above entities, but will not apply to information that has already been released pursuant to this authorization. My authorization for the use or disclosure of the information identified above is voluntary and I understand that a health care provider may not condition treatment on whether I sign this form. I also understand that I am entitled to a signed copy of this authorization.

REDISCLOSURE:

I understand that the requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's education record. The information will be shared with individuals working at or with the School District. If the disclosed information is not protected by FERPA, I understand that once it is disclosed, it may be redisclosed by the School District and the information may not be protected by federal privileges, privacy laws or regulations.

APPROVAL:

A copy of this release shall be as sufficient to authorize release of information identified above as the original signed by me. Unless sooner terminated in writing, this release shall remain effective for **1 year** from the date signed below. If the patient/student is under 18 years of age but is legally entitled to consent to treatment on his or her own behalf, the patient/student must sign this authorization.

______________________________ Date: ____________

Signature of Patient/Student or
Patient/Student's Parent or Legal Guardian Relationship: ____________