FRUITPORT COMMUNITY SCHOOLS

Authorization for Release of Information

Student Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: ____ Zip: _____ Phone: _____

Record Release:

I authorize my child's records to be sent FROM:

Name of Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I authorize my child's records to be sent TO:

Name of Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

_____ ***I authorize ongoing two-way written or oral communication during this school year***

Information Requested:

___ Discharge Summary ___ Medical ___ Vision

___ Educational Data/IEP ___ Speech/Language ___ Psychological

___ Records related to specific problem of: _____

Purpose of Disclosure:

___ Patient request ___ Attorney/Legal ___ Education

___ Other (Specify)
_____

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part by any other agency, organization or person, except as required by law. I further understand that correspondence, patient discharge instructions and records from other health care providers may be released with this routine request.

There is potential that information disclosed under this Authorization may be disclosed by the recipient and may no longer be protected by Federal HIPAA regulations.

Your Rights:

You may refuse to sign this form. You may cancel it at any time by informing the Fruitport Community Schools District in writing. If you cancel your permission to allow the release of information about you/your child, it will go into effect immediately (unless someone already released information). You have a right to receive a copy of this Authorization.

Signature _____ Date _____

Indicate relationship to student: _____

Witnessed by: _____ Date _____

This authorization will expire at the end of the current school year.