Helena Public Schools
Permission To Release Or Exchange Information

Date:

Student Name: Birthdate:

Address (city/state/zip): Phone:

Name of Parent/Legal Guardian:

School Grade

As Parent/Guardian/Surrogate Parent or Adult Student (circle one), I authorize the release and exchange of confidential information between Helena Public Schools and:

Name/Agency/Suggested Contact	Telephone/Fax	Address, City, State, Zip
	Tel: Fax:	

The disclosure is to be used for the following purposes:

- ☐ To support student's educational needs
- ☐ To determine special education needs
- ☐ Alcohol and drug evaluation and/or treatment for a student, and referrals to school/other services
- ☐ Medical and health needs
- ☐ Program evaluation
- ☐ Other

(Specify):

Information released will include the following specific records:

- ☐ Student Information (may include student's name, address, telephone listing, photograph, date and place of birth)
- ☐ Academic Information
- ☐ Attendance Information
- ☐ Family Background Data
- ☐ Psychological Reports
- ☒ Psycho-educational Reports
- ☐ Social Work Reports
- ☐ Medical Information and Reports
- ☐ Individualized Education Program (IEP)
- ☐ Attendance at Meetings or Appointments
- ☐ Discipline Data (referrals, suspensions, expulsions)
- ☐ Recommendations and Referrals
- ☐ Alcohol/Drug Information and Reports
- ☐ Mental Health Information and Reports
- ☐ Other (specify):

The District reserves the right to charge for costs of providing records. The authorization is valid for two years unless otherwise specified. HIPAA requires that the District give a copy of the authorization form to individuals who sign it and request a copy.

I hereby approve the release of information and indicated above. I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. Any records containing drug and alcohol information maintained by the District are additionally protected under the provision of 42 CFR Chapter 1, Subchapter A, Confidentiality of Alcohol and Drug Abuse Patient Records and may not be further disclosed without specific authorization for such disclosure. By my signature, I hereby, knowingly and voluntarily authorize the above named agency/provider to use or disclose this information including health information, in the manner described above. I may revoke this authorization in writing at any time. Such revocation may not be retroactive.

x

Parents/Guardian/Surrogate/Adult Student Date

Please Print Name

Student signature is ONLY required when requesting mental health or alcohol/drug related information for a student who is 14 years of age or older.

x

Student Date

Please Print Name

Authorization expires on (month/day/year), not to exceed two years from date of signature(s) above

Please Send Records to:

Helena Public Schools or Department

Staff Name/Title

Address, City, State, Zip

Phone Fax