Request for Medical/Mental Health Records

OGDEN SCHOOL DISTRICT
Empowering Excellence Through Education

Student Name:	DOB:

I authorize the following provider and/ or facility to release specified information to Ogden City Schools.
Parents/ Legal Guardian Name:

Name of Provider or facility:

Address: City: Zip

The released information will be used for the purpose of gathering information in behalf if the said student.

The information to be released includes services provided from the student's birth to the date of the signing of this request form.

The specific information being requested is:

- ☐ *Diagnostic evaluation/examination reports*
- ☐ *Developmental/medical history*
- ☐ *Treatment plans or recommendations*
- ☐ *Admit/Discharge summaries*
- ☐ *Follow-up/ progress reports*
- ☐ *Other. Describe:*____

Send the requested information to:

Ogden School District, Student Services

Records will be viewed by the following:

- ☐ School Nurses
- ☐ Counselor
- ☐ LEA/ Principal
- ☐ School Support Staff
- ☐ District Section 504 Coordinator
- ☐ School Section 504 Coordinator
- ☐ School Psychologist
- ☐ Speech Pathologist
- ☐ Other: ______________________________

Address : Student Services 1950 Monroe Blvd. Ogden , UT 84401

Fax: 801-737-8869

This authorization shall remain in effect for six (6) months from the date of signing. The parent/guardian/ student at age of majority has the right to revoke this authorization by providing written notice to the health care provider consistent with the health care provides policies. Revocation does not affect releases of medical records made prior to the revocation.

The health care provider is not responsible for any further disclosures of the released information by the school/district. If the information is released to any individual or entity that is not legally required to keep it confidential, the information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or any other state or federal law.

The released medical records may become part of the student's education records, may be forwarded to another school in which the student seeks or intends to enroll, any may be examined by the parent/ guardian or the student at the age of majority.

Signing this form is voluntary. Refusing to sign it will not affect the school or district's commitment to provide an appropriate education for the student. However, the requested records may be required in order for the school to implement an appropriate plan of education in the most timely manner. The parent/guardian or student at of majority has a right to a copy of this from after signing.

By my signature below, I authorize the release and use of the information in accordance with the rights, restrictions and understanding above.

_______________________________________ _______________________
Signature of parent/legal guardian/student at age of majority Date Signed

_______________________________________ _______________________
Printed name of parent/legal guardian/ student at age of majority Date authorization expires