

# Request/Release Medical/Mental Health Records and Information



Student Name:	DOB:
Parents/ Legal Guardian Name:	

I authorize the following provider and/ or facility to release specified information to Ogden City Schools.

Name of Provider or Facility:		
Address:	Phone:	
City:	State:	Zip:

The specific information being requested is two-way communication and:

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

Send the requested information to:

Name:	Title:	
Address:	Phone:	Fax:
Email:		

This authorization shall remain in effect for one year 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 provider's 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 timeliest 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 and two-way communication between agencies 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