



# Request of Medical/Mental Health Records

The release information will be used for the purpose of facilitating the special education of the student and/or facilitating the development of a special education services plan for the student. The information to be release includes services from the student's birth to the date of the signing of this request form.

Student:	DOB:
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**I authorize the following provider and/or facility agency to release specified information to Ogden City Schools:**

Name of provider:	
Name of facility:	
Address:	City, State Zip
Phone:	Fax:

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

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

**Send requested information to:**

Name of contact person:	
Name of School or organization:	
Address:	City, State Zip
Phone:	Fax:

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 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 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. The school and Individuals with Disabilities Education Improvement Act (IDEIA).

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 age of majority has a right to a copy of this form after signing.

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

\_\_\_\_\_  
Signature of parent/legal guardian/student at age of majority

\_\_\_\_\_  
Printed name of parent/legal guardian/student at age of majority

\_\_\_\_\_  
Date Signed