

SCHOOL BOARD OF BROWARD COUNTY

AUTHORIZATION FOR RELEASE AND/OR REQUEST FOR INFORMATION

I hereby request and authorize: Persons involved in providing input/information so
(Name of Person and/or School/Agency)
that student can safely attend school, per HIPAA regulations to engage
(Street Address) (City) (State) (Zip) (Telephone #)

in verbal and/or written communication with and release records to: Persons involved in provision of
(Name of Person and/or School/Agency)
appropriate services while in school, per HIPAA regulations.
(Street Address) (City) (State) (Zip) (Telephone #)

regarding the **information checked below** concerning my child _____, whose date of birth is _____. I understand that information concerning psychiatric, psychological, medical diagnosis, drug or alcohol abuse and educational information regarding my child may be released and/or communicated. I further understand that this information might contain information regarding my family, in addition to my child.

- | | |
|---|--|
| _____ Treatment Plans | _____ Substance Abuse Treatment Records |
| _____ Discharge Summaries | _____ Social and/or Developmental History |
| _____ Health/Medical Records | _____ Psychological and/or Psychiatric Evaluations |
| _____ School/Education Records | _____ HIV/Acquired Immune Deficiency Syndrome test results or related conditions |
| _____ Case/Progress/Therapy Notes | |
| _____ Exceptional Student Education/Section 504 Records | |
| _____ Other _____ | |
| _____ Other _____ | |

For the Purpose of: _____

All information I authorize to be released or requested will be held strictly confidential and cannot be released by the recipient without an additional written consent. I understand this authorization will expire one (1) year after the date signed, or on _____, 20____, whichever is earlier. A copy of this authorization is valid in lieu of the original. I further understand I may withdraw my consent at any time.

Print Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Date

Relationship to Child

(USE THIS SPACE IF CONSENT IS WITHDRAWN)

Date Consent Is Withdrawn

Signature of Parent or Legal Guardian