AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, do hereby request and authorize
(Name of parent, guardian, student if 18 years of age)

MSAD No. 75 Public Schools ☐ to release to, ☐ obtain from, and/or ☐ discuss with

_____
(Name and address of agency, physician, or hospital)

Information regarding _____ (_____/_____/_____)
(Student name) (Student date of birth)

For purpose of:

☐ Educational Planning ☐ Ongoing Treatment/Aftercare ☐ To coordinate treatment efforts

☐ Other (please specify): _____

This information may include:

☐ Special Education Records ☐ Progress Notes ☐ Medical ☐ Consultations

☐ Complete Record ☐ Psychiatric Evaluation ☐ Treatment Plan ☐ Intake Evaluation

☐ Diagnostic Tests ☐ Discharge Summary ☐ Other Records: _____

I DO authorize the disclosure of information which refers to treatment or diagnosis of **DRUG OR ALCOHOL ABUSE**. If I authorize the release of such information, I understand that it cannot be re-disclosed by a recipient without my specific consent.	I DO NOT: _____ (Initial here)
I DO authorize the disclosure of information which refers to treatment or diagnosis of **HIV** infection or **AIDS.**	I DO NOT: _____ (Initial here)
I DO authorize disclosure of information which refers to treatment or diagnosis of **MENTAL HEALTH**	I DO NOT: _____ (Initial here)

- ❖ This consent has been made freely, voluntarily, and without coercion.
- ❖ I was able to ask questions and receive answers about this release.
- ❖ I hereby authorize releasing/obtaining of the information as specified above and further understand that those who receive this information cannot disclose it to others without my further consent, unless permitted by Federal or State Law.
- ❖ I understand that I may revoke this authorization at any time.
- ❖ This authorization is effective for a period of one year from the date of signing.
- ❖ This release is valid only for the purpose stated. MSAD No. 75 Public Schools must obtain my written authorization before releasing any further information to any other agency.

I do hereby release MSAD No. 75 Public Schools and this agency/physician from all liability and all claims pertaining to the disclosure of this information when used as authorized.

_____ _____
Signature of parent, guardian or student (18 years of age) Date

_____ _____
Printed Name of authorized representative Date

_____ _____
Witness Date

Revised (03/30/2021)