AUTHORIZATION FOR EXCHANGE OF MEDICAL INFORMATION
Bethel School District #403

SECTION I Information Requested From

Name of Agency _____ Name of Person Disclosing Information _____

Address _____ Title _____

Name of Student _____ Date of Birth _____ Today's Date _____

Specific nature/purpose of information to be disclosed: _____

SECTION II – Authorization

I hereby authorize the release of medical information in Section I to the individuals who are affiliated with the school/agency indicated in Section II. This authorization expires in 90 days after the date it is signed.

Expires On: _____

My Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the privacy notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re disclose it, at which time it may no longer be protected in privacy laws.

Parent and/or Legal Representative Signature _____ Date _____

Student Consent: A minor patient's signature is required in order to release the following information: (1) HIV/AIDs status, diagnosis, treatment 14 years of age; (2) family planning/abortion no age limit; (3) alcohol/drug treatment 13 years of age; and (4) mental health services 13 years of age.

Student Signature _____ Date _____

SECTION III – Agency Receiving Information

School District: _____

Address: _____

Name of School Psychologist: _____

Name of School Nurse: _____

Name of Other (Title): _____