

**HOWARD COUNTY PUBLIC SCHOOL SYSTEM
AUTHORIZATION FOR RELEASE OF RECORDS**

Name of Student _____

Student's Birthdate _____

Request Date _____

Request for Records from:

Name _____

Title _____

Agency _____

Address _____

Phone _____

Fax _____

Request Initiated by:

Name _____

Title _____

School _____

Address _____

Phone _____

Fax _____

____ School Social Worker ____ School Counselor ____ School Psychologist ____ Pupil Personnel Worker ____ Health Services of the Office of Student Services, Howard County Public School System, is requesting the following records on the above named student. The records are being requested for the following reasons: _____

Information Requested:

____ Telephone Consultation

____ Discharge Reports

____ Assessments _____

____ Diagnostic Information

____ Treatment Plan/Medication Information

____ Other _____

Parent/Guardian Authorization:

I, (name of parent/guardian) _____, authorize the disclosure of medical records noted above for the student specified above for school purposes to the individuals affiliated with the school as indicated above. I understand that, if the persons or organizations I authorize to receive and/or use the medical records are not subject to the federal or state health information privacy laws, they may further disclose these records, in which case, it may no longer be protected by the Health Information Portability and Accountability Act (HIPAA) privacy laws.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to my provider. In order to obtain a revocation form to revoke this authorization, I understand that I may contact my provider's office. I understand that revocation of this authorization will not affect any action that those named or unnamed herein, took in reliance on this authorization before my provider received my written notice of revocation.

As the sending party, you should be aware that the parent(s)/guardian(s) have the right to review and obtain a copy of the student's records on file in the Howard County Public School System. **I give permission for the release of records listed above.** A photocopy or a fax transmission of this authorization shall be deemed as valid as an original signature.

Parent/Legal Guardian Signature

Date

Information Released from Howard County Public School System

I give permission for the Howard County Public School System to release the following records:

____ Telephone Consultation

____ Discharge Reports

____ Assessments _____

____ Diagnostic Information

____ Treatment Plan/Medication Information

____ Other _____

Send to: _____

Name of Agency/Individual and Address

Parent/Legal Guardian Signature

Date