ANCHORAGE SCHOOL DISTRICT
CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of the individually identifiable health and educational information described below for the named patient/student. If the patient/student is under 18 years of age but is legally entitled to consent to treatment on his or her own behalf, the patient/student must sign this authorization. A parent or legal guardian is not entitled to receive or consent to the release of medical records for which the patient/student was legally allowed to consent for treatment on his or her own behalf.

Patient/Student Name_____

Social Security Number_____

Birth Date_____

Persons/Organizations Authorized to <u>Provide</u> the Information:

Name_____

Address_____

City/State/Zip Code_____

Persons/Organizations Authorized to <u>Receive</u> the Information:

Name_____

School_____

Address_____

City/State/Zip Code_____

Specific Information Authorized to be Disclosed:

_____Psychological Testing _____Educational Records _____Diagnostic Summary
_____Verbal Information _____Discharge Summary _____Medical Records

This information is for the purpose of:
_____Special Education Evaluation & Planning _____504 Evaluation & Planning
_____Information for School Nursing

I understand the information to be released may include information about:

_____Drug/alcohol abuse, treatment, rehabilitation _____Psychiatric Treatment

Any information disclosed will not be released by the above-named person(s)/organization(s) to any other person(s)/organization(s) unless I so authorize.

This authorization will remain effective for 180 days from the date signed below.

However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that the providing persons/organizations set forth above have taken action in reliance on this authorization before receiving the written revocation.

I understand I have a right to receive a copy of this Consent for Release of Information.

_____ Date:_____
Signature of Patient/Student or
Patient/Student's Parent or Legal Guardian

_____
Please print name

If signed by parent or legal guardian, please state relationship to the patient/student:

_____

Revocation of Authorization- Do Not Sign Below Unless You Wish to Revoke Authorization

I understand that by signing below, I am revoking my prior authorization of the release of medical records to the above mentioned party except that the revocation will not be effective to the extent that any party listed above relied on my prior authorization.

_____ Date:_____
Signature of Patient/Student or
Patient/Student's Parent or Legal Guardian

JDO/Forms/98289
Rev. Date 2/02/05