SCHOOL UNION 113
45 North Street
East Millinocket, Maine 04430
(207) 746-3500

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Student Name:_____ DOB:_____

I, _____, hereby authorize personnel at School Union 113:
Client/guardian

To RECEIVE the following information:	**To DISCLOSE the following information:**
(Please check the appropriate box(es))	*(Please check the appropriate box(es))*
❒ Any and all information relating to the care, education and treatment about the above-named student.	❒ Any and all information relating to the care, education and treatment about the above-named student.
❒ **Only** the following information: ❒ Demographics ❒ Assessment ❒ Admission History ❒ Progress Notes ❒ Treatment Plan ❒ Discharge Summary ❒ Pertinent Social History ❒ Other (please specify) _____ _____	❒ **Only** the following information: ❒ Demographics ❒ Assessment ❒ Individual Education Plan ❒ Academics/Report Card ❒ Treatment Plan ❒ Day Treatment Services information ❒ Other (please specify) _____ _____

Information to be RECEIVED FROM/DISCLOSED TO:

Company/Agency:_____ Name: _____

Address: _____

The purpose of this release is:

❒ Coordination of services ❒ Obtain records ❒ Determine eligibility for services
❒ Legal purposes ❒ ISP/IEP planning
❒ Other (please specify) _____

I DO ❒ *DO NOT* ❒ authorize release of any information that may be covered by federal rules relating to the confidentiality of alcohol or drug abuse treatment.

I DO ❒ *DO NOT* ❒ authorize release of any information that may relate to diagnosis/treatment for HIV, ARC, or AIDS.

I DO ❒ *DO NOT* ❒ authorize release of any information that may relate to mental health treatment.

Unless earlier revoked, this authorization will remain in effect until _____(**maximum 1 year**). I authorize the above-named provider to make subsequent disclosures to the same recipient pursuant to this authorization.

I understand that the above information may be covered by the rules of the Maine Department of Behavioral and Developmental Services (the "Rights of Recipients of Mental Health Services" or the "Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment").

I understand that I may refuse to release some or all of the information in the provider's records, but that such refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or insurance, or other adverse consequences. The provider will not deny treatment on signing this authorization, unless the health care is solely for purpose of creating the information listed above for the person listed above.

Per district standards, Union 113 will NOT release information created by other practitioners or facilities. Statements added to records by students and/or guardians will not be released without written consent. I understand that if the above listed information is disclosed, it is possible that it may be redisclosed by the recipient, or that it may no longer be subject to confidentiality protections.

Student Name: _____

I waive my right to review this information prior to its disclosure: ❒ Yes ❒ No

I authorize the provider to send/receive these records by fax: ❒ Yes ❒ No FAX#_____

I acknowledge that I have been offered a copy of this authorization: ❒ Yes ❒ No

I understand that I may cross out any words on this form with which I disagree, and that I may revoke this authorization at any time.

Signatures:

Student (*Recommended at age 14)* _____ Date _____

Authorized Representative _____ Date _____

Relationship to Client _____

Witness _____

** * * Request to Revoke Statement below. * * **

* * * Request to Revoke * * *

I understand that I may revoke this authorization at any time by giving written notice to Union 113 using this form or any other written statement. This will not affect information released prior to receiving my request to revoke. I understand that revoking this authorization may be the basis for denial of health benefits or other insurance coverage benefits.

My signature below officially revokes this authorization:

Student (*Recommended at age 14*) _____ Date Revoked _____

Authorized Representative _____ Date Revoked _____

Relationship to Client _____

Witness _____

Second reading and adoption: March 2, 2010