LAFAYETTE PARISH SCHOOL SYSTEM

AUTHORIZATION TO RELEASE or OBTAIN CONFIDENTIAL INFORMATION

(including paper, oral and electronic information)

PART 1: STUDENT INFORMATION

Name: _____Request Date:_____
Mailing Address:_____ Date of Birth:_____
City/State/Zip: _____
Medicaid # _____ Social Security #:_____

I authorize:

Name: _____
Mailing Address: _____
City, State, Zip Code: _____
Relationship: _____ Telephone Number:_____

❒ **TO RELEASE Information TO OR** ❒ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____
Mailing Address: _____
City, State, Zip Code: _____
Relationship: _____ Telephone Number:_____

PART 2: RECORD REQUEST Complete box A or box B below. Both may not be completed on the same form.

A. Specify the records to be released.

❑ COMPLETE RECORD(S)
❑ Discharge Summary
❑ History & Physical
❑ Diagnosis
❑ Medication, medication history, side effects
❑ Progress Notes
❑ Lab
❑ Other _____

B. If initialed below, I specifically authorize release of the following:
Psychotherapy notes and records indicating psychological or psychiatric impairment(s)

_____
Initials of parent/legal guardian

PART 3: PURPOSE OF AUTHORIZATION

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Provide best educational program for child ❒ Treatment within educational setting
❒ Evaluation to determine eligibility or continued eligibility for special education services
❒ Other: (Specify)_____

_____I DO _____I DO NOT authorize the release of the following: drug and alcohol use counseling and treatment and HIV/AIDS and sexually transmitted disease testing and treatment. (Please initial one or the other.)

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the same medical records department receiving this authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability & Accountability Act of 1996.
I understand that my child's evaluation is not conditioned on the signing of this authorization. _____ (please initial)

_____	_____	_____
Signature of Student or Legal Representative (Parent or Legal Guardian must sign if student <18)	Date	Relationship to Student

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Signature of Witness	Date	Position

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