Maryville R-II School District
1429 S. Munn Avenue
Maryville, MO 64468

AUTHORIZATION FOR CONSENT FOR RELEASE OF INFORMATION

(including identifiable health information)

Name of Student: Grade: Date of Birth:
Social Security Number:

EXCHANGE OF INFORMATION BETWEEN BOTH SCHOOLS/AGENCIES LISTED

(Information may be exchanged both ways):

School/Agency:
Person authorized to disclose information (Name or Title):
OR Released To (Name or Title):
Address:
Phone:
Fax:

and

School/Agency: Maryville R-II School District
Person authorized to disclose information (Name or Title):
OR Released To (Name or Title):
Address: Maryville, MO 64468
Phone: (660) 562-
Fax: (660) 562-

Please disclose/release OR you will be receiving the specified information below:

- ☐ Audiometric
- ☐ Educational Cumulative Record
- ☐ Medical/Health
- ☐ Occupational Therapy
- ☐ Special Education Records
- ☐ Physical Therapy
- ☐ Psychiatric
- ☐ Psychological
- ☐ Social Work
- ☐ Exchange of information via telephone/mail
- ☐ Speech/Language
- ☐ Other:
- ☐ Other:
- ☐ Other:

Further description of information being requested (if applicable):

Purpose(s)/reason(s) for which the information may be used or disclosed:

☐ Educational Planning or ☐ Other (specify):

List of individuals who will be able to know the above information:

See above

I have been informed of the reason and need for this exchange of information. I understand that all information exchanged by these persons or agencies is confidential and will not be disclosed to any other party without prior written consent of the parent or legal guardian except as permitted by law. The protected health information in my record may include mental/behavioral health information. This authorization includes both information presently compiled and information to be compiled during the course of my education or treatment at the schools and/or agencies listed above. Information exchanged by these persons or agencies may be used only for the purpose for which it was released.

I authorize and request the above named schools and/or agencies to disclose/release the above specified information to the schools and/or agencies listed above effective as of the date below. I understand that I have a right to revoke this authorization at any time. If I revoke this authorization I must do so in writing. I understand the information released pursuant to the authorization is subject to re-disclosure by the recipient and may no longer be protected by the HIPAA rule it may have been obtained under. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected. I understand that I have the right to receive a copy of this authorization. Services may not be conditioned on whether I sign this authorization. A photographic copy or fax of this authorization is as valid as the original.

_____ _____

Parent/Guardian and/or Student (18 years or older) Date

Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____ Expiration Date (not to exceed 12 months). If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed.

_____ _____

Name-School Personnel Date