Great Falls Public Schools
P.O. Box 2429
Great Falls, MT. 59403
Phone: (406) 268-6025

OFFICIAL RELEASE OF CONFIDENTIAL INFORMATION

Date: _____

Student Name: _____ **Birth Date:** _____

To:

_____
_____
_____
_____

Please send information to: (GFPS)

_____
_____
_____
_____

☐ **I authorize the released information to be exchanged with** _____
(Name of Primary Care Physican)

Reason for requesting information: _____

I hereby authorize the above-mentioned agency or individual to (check all that apply):

☐ Release Information to GFPS

☐ Obtain Information from GFPS

☐ Exchange Information with GFPS

Dates of Service: _____ TO _____

The information to be released (check all that apply)

☐ Official School Records (including Special Education records and health records)

☐ Medical

☐ Speech/Language/Audiological

☐ Psychological

☐ Teacher, Counselor, Staff Observations and Impressions.

☐ Homebound Verification

☐ Life Threat Assessment

☐ Legal

____ *(Initials)* Psychotherapy Notes

____ *(Initials)* HIV/AIDS Diagnosis

AUTHORIZATION

This authorization is valid for one calendar year. It will expire _____ (Insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Act. I also understand that the facility where the records are acquired may not condition the provision of treatment, payment or enrollment in a health plan or eligibility for benefits on my failure to provide an authorization of release of my child's protected health information except as limited by that facilities condition under the HIPAA Privacy Act. I understand that revocation is not possible once disclosure has been released.

_____
Signature Parent/Guardian/Surrogate/Adult Student

_____
Date

☐ If no records are available, please check here and return this form.