Mohonasen
CENTRAL SCHOOL DISTRICT

Shannon Shine, *Superintendent of Schools*
2072 Curry Road, Schenectady, NY 12303, (518) 356-8200

# HIPAA COMPLIANT MEDICAL INFORMATION RELEASE

TO:

I, _____, parent/legal guardian of _____, D.O.B. _____ do hereby voluntarily authorize _____ to provide copies of records to and discuss my child's evaluation and/or treatment plan (including psychiatric evaluation, psychological testing related to psychiatric and/or other mental health impairments, counseling information and/or psychotherapy notes) and any relevant findings and recommendations with authorized representatives of the Mohonasen Central School District as it relates to educational needs, social/emotional, behavioral and functional needs and planning for my child's education.

I also authorize _____ to confer with the District staff and to obtain copies of any relevant educational records, reports, documents and prior evaluations which may assist the provider in evaluating the student, and making recommendations regarding the student's diagnosis, prognosis and educational, social-emotional, behavioral and functional needs.

This authorization is good for 12 months from the date signed below. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written revocation to the Mohonasen Central School District. I understand that if I revoke this authorization to release information, any records released prior to my revocation are still valid. I understand that records, once released per my authorization, may be re-disclosed by individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA.

Date: _____ Signed: _____

Name (Print): _____

Relationship to Student: Parent/Legal Guardian

***Completed form should be returned to the student's school.***