Caroline County PUBLIC SCHOOLS
ONE FAMILY. ONE VISION.

Student Services
204 Franklin Street, Denton, MD 21629
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student.services@ccpsstaff.org

Authorization for Release of Information

Patient/Student's Name_____ **D.O.B.**_____

Written exchange of information relevant to reason for this request.*

I hereby authorize_____
(name & address of person, agency or organization)
to release my/my child's health/immunization or education information records or documents for the purpose(s) listed below to_____
(name & address of person, agency or organization)

Verbal exchange of information relevant to reason for this request.*

I hereby authorize_____ and_____
(name & address of person, agency or organization) (name & address of person, agency or organization)
to verbally exchange my/my child's health/immunization and education information/records for the purpose(s) listed below.

Information will be communicated only via the completed boxes above.

Description:
The information to be disclosed consists of:

- ☐ Special Education Records
- ☐ Psychological/Psychiatric Evaluation
- ☐ Immunizations as Required by Annotated Code of Maryland, Educ §7-403
- ☐ Other Medical Records_____
- ☐ Official School Records
- ☐ ELL Records
- ☐ Treatment Order
- ☐ Medication Order

Purpose:
This information will be used for the following purposes(s)

- ☐ Enrollment in School
- ☐ Educational Evaluation and Program Planning
- ☐ Other_____
- ☐ Medical Evaluation/Treatment
- ☐ Health Assessment & Planning for Health Care Services & Diagnosis in School

Authorization:
I, (name of parent or guardian)_____, authorize the disclosure of the above specified health/immunization and educational records as indicated above. I understand that, if the persons or organizations I authorize to receive and/or use the immunization records are not subject to the federal or state health information privacy laws, they may further disclose the immunization records, in which case, it may no longer be protected by the health information privacy laws.

This authorization is valid for one calendar year. It will expire on _____ 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 records received by the school system may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA) and become part of the student's cumulative record. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Signature of Parent/Guardian or Student if over 18 Date

Printed Name, Address and Telephone Number Date

Signature of Student* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Maryland, a competent minor, depending on age, can consent to outpatient mental health care, drug and alcohol abuse treatment, testing for HIV/AIDS, and reproductive health care services.

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