

**SCHOOL UNION 113**  
 45 North Street  
 East Millinocket, Maine 04430  
 (207) 746-3500

**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize personnel at School Union 113:  
 Client/guardian

<p><b>To RECEIVE the following information:</b>                  (Please check the appropriate box(es))</p> <p><input type="checkbox"/> Any and all information relating to the care, education and treatment about the above-named student.</p> <p><input type="checkbox"/> <b>Only</b> the following information:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Demographics</li> <li><input type="checkbox"/> Assessment</li> <li><input type="checkbox"/> Admission History</li> <li><input type="checkbox"/> Progress Notes</li> <li><input type="checkbox"/> Treatment Plan</li> <li><input type="checkbox"/> Discharge Summary</li> <li><input type="checkbox"/> Pertinent Social History</li> <li><input type="checkbox"/> Other (please specify) _____</li> </ul>	<p><b>To DISCLOSE the following information:</b>                  (Please check the appropriate box(es))</p> <p><input type="checkbox"/> Any and all information relating to the care, education and treatment about the above-named student.</p> <p><input type="checkbox"/> <b>Only</b> the following information:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Demographics</li> <li><input type="checkbox"/> Assessment</li> <li><input type="checkbox"/> Individual Education Plan</li> <li><input type="checkbox"/> Academics/Report Card</li> <li><input type="checkbox"/> Treatment Plan</li> <li><input type="checkbox"/> Day Treatment Services information</li> <li><input type="checkbox"/> Other (please specify) _____</li> </ul>
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**Information to be RECEIVED FROM/DISCLOSED TO:**

Company/Agency: \_\_\_\_\_ Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

**The purpose of this release is:**

- Coordination of services
- Obtain records
- Determine eligibility for services
- Legal purposes
- ISP/IEP planning
- Other (please specify) \_\_\_\_\_

- I DO  **DO NOT**  authorize release of any information that may be covered by federal rules relating to the confidentiality of alcohol or drug abuse treatment.
- I DO  **DO NOT**  authorize release of any information that may relate to diagnosis/treatment for HIV, ARC, or AIDS.
- I DO  **DO NOT**  authorize release of any information that may relate to mental health treatment.

Unless earlier revoked, this authorization will remain in effect until \_\_\_\_\_ (**maximum 1 year**). I authorize the above-named provider to make subsequent disclosures to the same recipient pursuant to this authorization.

I understand that the above information may be covered by the rules of the Maine Department of Behavioral and Developmental Services (the "Rights of Recipients of Mental Health Services" or the "Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment").

I understand that I may refuse to release some or all of the information in the provider's records, but that such refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or insurance, or other adverse consequences. The provider will not deny treatment on signing this authorization, unless the health care is solely for purpose of creating the information listed above for the person listed above.

Per district standards, Union 113 will NOT release information created by other practitioners or facilities. Statements added to records by students and/or guardians will not be released without written consent. I understand that if the above listed information is disclosed, it is possible that it may be redisclosed by the recipient, or that it may no longer be subject to confidentiality protections.

Student Name: \_\_\_\_\_

I waive my right to review this information prior to its disclosure:  Yes  No

I authorize the provider to send/receive these records by fax:  Yes  No FAX# \_\_\_\_\_

I acknowledge that I have been offered a copy of this authorization:  Yes  No

I understand that I may cross out any words on this form with which I disagree, and that I may revoke this authorization at any time.

**Signatures:**

Student (Recommended at age 14) \_\_\_\_\_ Date \_\_\_\_\_

Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Client \_\_\_\_\_

Witness \_\_\_\_\_

**\*\*\* Request to Revoke Statement below. \*\*\***

**\*\*\* Request to Revoke \*\*\***

I understand that I may revoke this authorization at any time by giving written notice to Union 113 using this form or any other written statement. This will not affect information released prior to receiving my request to revoke. I understand that revoking this authorization may be the basis for denial of health benefits or other insurance coverage benefits.

**My signature below officially revokes this authorization:**

Student (Recommended at age 14) \_\_\_\_\_ Date Revoked \_\_\_\_\_

Authorized Representative \_\_\_\_\_ Date Revoked \_\_\_\_\_

Relationship to Client \_\_\_\_\_

Witness \_\_\_\_\_

First reading: February 2, 2010

Second reading and adoption: March 2, 2010