boe.jack.k12.wv.us
PHONE (304) 372-7300
FAX (304 372-7312

JACKSON COUNTY SCHOOLS

BOARD OF EDUCATION – OFFICE OF SUPERINTENDENT
P.O. BOX 770, RIPLEY, WEST VIRGINIA 25271

This form authorizes the recipient, _____ to disclose protected health information in the manner described below and is voluntary. The provider will not condition treatment, payment, entitlement or eligibility for benefits on the execution of this Authorization. The information disclosed as a result of this Authorization will be used for the purpose of:
☐ **educational programming** ☐ **behavioral support** ☐ **identification/evaluation/eligibility for IDEA or ADA/Section 504 Services** ☐ **individualized health care plan,** and is protected under the Family Education Rights and Privacy Act (FERPA).

PHYSICIAN/PROVIDER/AGENCY _____ **TELEPHONE**: _____
ADDRESS: _____ **FAX NUMBER**: _____

Student/Patient Information

STUDENT: _____ **GENDER**: ☐ M ☐ F **DATE OF BIRTH**: _____
LAST FIRST MI

PARENT/GUARDIAN: _____

ADDRESS: _____ **TELEPHONE**: _____

CITY/STATE: _____ ZIP: _____ **EMAIL**: _____

PHYSICIAN/PROVIDER/AGENCY: _____

ADDRESS: _____ **TELEPHONE**: _____

CITY/STATE: _____

Release To

NAME: _____ **SCHOOL**: _____

ADDRESS: _____ **TELEPHONE**: _____

CITY/STATE: _____ ZIP: _____ **EMAIL**: _____

METHOD OF RELEASE: ☐ Mail ☐ Electronic Mail ☐ Fax Number _____ ☐ Pick Up By _____
☐ Checking this box provides consent for two-way communication between above listed provider and Jackson County Schools. Authorized personnel in addition to the above named: _____

Information to Release

Dates of Treatment Requested: Last two years of active treatment will be provided unless specified. Dates: _____

☐ History & Physical ☐ Inpatient Consult Reports (Specify) _____ ☐ Discharge Summary
☐ Immunizations ☐ Outpatient Clinic Notes (Specify) _____ ☐ Physician Progress Notes
☐ Psychiatric Mental Health ☐ Other (Specify) _____

Patient/Parent/Legal Guardian

I understand that by signing this authorization, I am giving permission to disclose all the records I have specified for release to the designated recipient. Unless indicated above, I specifically authorize the release to include such confidential health information as may be contained in the records which may relate to behavioral or mental health services, treatment for alcohol and drug abuse, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).
I understand that authorizing the disclosure is voluntary. I can refuse to sign this authorization. I understand that, once medical information is disclosed to an educational agency, it is protected under FERPA; however, is no longer subject to the protection of the Health Insurance Portability and accountability Act of 1996 (HIPPA).
I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to all parties involved. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, the authorization will expire one year from the date signed or, if specified, on the following date: _____.

Signature of Patient (if 18 or older) _____ **Date**: _____

Signature of ☐ Parent ☐ Legal Guardian ☐ GAL/CASA: _____ **Date**: _____