



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 _____ ADDRESS: _____	TELEPHONE: _____ FAX NUMBER: _____
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Student/Patient Information	STUDENT: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> LAST FIRST MI </div>	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH: _____
	PARENT/GUARDIAN: _____		
	ADDRESS: _____		TELEPHONE: _____
	CITY/STATE: _____		ZIP: _____
	PHYSICIAN/PROVIDER/AGENCY: _____		
ADDRESS: _____		TELEPHONE: _____	
CITY/STATE: _____			

Release To	NAME: _____		SCHOOL: _____	
	ADDRESS: _____		TELEPHONE: _____	
	CITY/STATE: _____		ZIP: _____	
	EMAIL: _____ METHOD OF RELEASE: <input type="checkbox"/> Mail <input type="checkbox"/> Electronic Mail <input type="checkbox"/> Fax Number _____ <input type="checkbox"/> Pick Up By _____ <input type="checkbox"/> 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: _____		
	<input type="checkbox"/> History & Physical <input type="checkbox"/> Inpatient Consult Reports (Specify) _____ <input type="checkbox"/> Discharge Summary		
	<input type="checkbox"/> Immunizations <input type="checkbox"/> Outpatient Clinic Notes (Specify) _____ <input type="checkbox"/> Physician Progress Notes <input type="checkbox"/> Psychiatric Mental Health <input type="checkbox"/> 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 <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> GAL/CASA: _____ Date: _____	

