School Administrative Unit #24

Districts of

Stoddard Henniker Weare John Stark

PERMISSION TO DISCLOSE RECORDS (HIPAA-COMPLIANT)

Check appropriate box

☐ I, , an adult student (age 18 or older)(DOB:),

☐ I, , parent/legal guardian of ,
a minor student (DOB:),

hereby authorize School District, hereafter referred to as "provider(s)," to disclose all records and information in their possession regarding the student to School District.

The School District's mailing address is .

This authorization allows the above provider(s) to copy and send records to School District and allows representatives of School District to inspect the records. This authorization also allows the above provider(s) to orally disclose information to School District, including but not limited to information contained in records.

This authorization encompasses *all* records pertaining to the student, including but not limited to correspondence, notes, reports, questionnaires, application forms, contracts, billing records, payment records, insurance records, work samples, discipline records, report cards, teacher grade books (with other students' names redacted), test protocols (questions and answers), test score calculations, any other test records, medical records, health records, counseling records, mental health records, computer data, *and "third party records"* created by any other individuals or organizations. The term "records" includes information recorded, maintained or preserved in *any* medium, including but not limited to printed, handwritten, magnetic, or electronic.

☐ I specifically authorize the release of HIV/AIDS results and/or treatment, where applicable.
☐ I specifically authorize the release of psychiatric records, where applicable.
☐ I specifically authorize the release of alcohol and substance abuse treatment records, where applicable.

Any costs for photocopying these records for School District, or for mailing these records to School District, shall be at School District's expense.

Pursuant to HIPAA, the following are specified as part of this authorization:

a. The purpose of disclosure is to help the School District identify the student's needs and provide appropriate educational services.
b. This authorization expires one year after the date it is signed.
c. The person signing this form understands that he or she may revoke this authorization at any time by providing written notification to School District or to the provider(s) named above, except to the extent that this authorization has already been relied on.
d. The person signing this form has been informed that the provider(s) named above may not condition treatment, payment, enrollment, or eligibility for benefits on whether that person signs this authorization.
e. The person signing this form has been informed of the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to be no longer protected by HIPAA. However, the federal Family Educational Rights and Privacy Act (FERPA) generally prohibits the School District and its employees and agents from disclosing student records (or information from those records) without prior written parental consent.

Date:_____ By: _____
Student/Parent/Legal Guardian