Portland Public Schools
Authorization for Release of Information

I, ______________________________________, do hereby request and authorize Portland Public Schools
(Name of parent or guardian)

☐ release to, ☐ obtain from, and/or ☐ discuss with ____
(Name and address of agency, physician or hospital)

information regarding _____________________________.
(Name of student)

This information may include:

☐ Medical H & P ☐ Progress Notes ☐ Complete Record ☐ Intake Evaluation

☐ Consultations ☐ Psychiatric Evaluation ☐ Discharge Summary ☐ Treatment Plan

☐ Diagnostic Tests ☐ Other Records _________________________

☐ I DO ☐ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. If I authorize the release of such information, I understand that it cannot be redisclosed by a recipient without my specific consent.

☐ I DO ☐ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.
☐ I DO ☐ I DO NOT wish to review such information prior to its release. Review must be supervised.

I DO NOT authorize disclosure of information which refers to treatment or diagnosis of HIV infections or AIDS.

For purposes of:
☐ Educational ☐ Ongoing Treatment/Aftercare ☐ To coordinate treatment efforts
☐ Other (please specify) ____

- This consent has been made freely, voluntarily, and without coercion.
- I was able to ask questions and receive answers about this release
- I hearby authorize releasing/obtaining of the information as specified above and further understand that those who receive this information cannot disclose it to others without my further consent, unless permitted by Federal of State law.
- I understand that I may revoke this authorization at any time.

This authorization is effective for a period of one year from the date of signing.

Note: This release is valid only for the purpose stated. Portland Public Schools must obtain my written authorization before releasing any further information to any other agency. I do hereby release Portland Public Schools and this agency/physician from all liability and all claims pertaining to the disclosure of this information when used as authorized.

_______________________________________ _________________________
(Signature of parent, guardian, student) (Date)

_______________________________________ _________________________
(Witness) (Date)

Please forward records to:

School: ____

Address: ____

Phone & Fax: ______________________ Nurse: ______________________