

# Natchitoches Parish School Board

310 Royal Street \*P O Box 16  
NATCHITOCHEs, LOUISIANA 71457-0016  
Phone (318) 352-2358  
**\*FAX (318) 354-9719 Pupil Appraisal**

## CONSENT TO DISCLOSE INFORMATION

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ SCHOOL: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

To Whom It May Concern:  
I hereby authorize Natchitoches Parish School System:

To **OBTAIN** information from: \_\_\_\_\_ **And/OR** \_\_\_\_\_  To **RELEASE** Information to:  
(School System, Hospital, Physician, Service Agency, School RN, and/or other health provider)

\_\_\_\_\_  
\_\_\_\_\_

Information requested includes **complete** records of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Educational Records  | <input type="checkbox"/> Medical diagnosis(es)  |
| <input type="checkbox"/> IEP <input type="checkbox"/> Evaluation <input type="checkbox"/> FBA/BIP | <input type="checkbox"/> Prescribed medications |
| <input type="checkbox"/> Psychological Evaluation   | <input type="checkbox"/> Discharge summary      |
| <input type="checkbox"/> Recommendations  | <input type="checkbox"/> Other _____            |

<p><b>The information is to be released for the purpose(s) of :</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Evaluation to determine eligibility or continued eligibility for special education services</li> <li><input type="checkbox"/> Providing physical therapy treatment</li> <li><input type="checkbox"/> Providing occupational therapy treatment</li> <li><input type="checkbox"/> Designing an Individualized Education Program (<b>IEP</b>)</li> <li><input type="checkbox"/> Developing an Individual Accommodation Plan (<b>IAP</b>)</li> <li><input type="checkbox"/> Individual Health Care Plan (<b>IHP</b>)</li> <li><input type="checkbox"/> Determining appropriate placement for treatment needs</li> <li><input type="checkbox"/> _____</li> </ul>
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I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the same medical records department receiving this authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_  
If I fail to specify an expiration date, event, or condition, this authorization will expire one year (12 months) from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability & Accountability Act of 1996.

\_\_\_\_\_  
**Date**  
**Return to:** Natchitoches Parish School Board  
Pupil Appraisal Services  
P O Box 16  
Natchitoches, LA 71457-0016

\_\_\_\_\_  
**Signature of Parent or Guardian**  
\_\_\_\_\_  
**Signature of Student (if 18 years of age or older)**

\_\_\_\_\_  
**Witness**

ATTN: \_\_\_\_\_