Natchitoches Parish School Board

SBLC-13

School _____
School Address: _____
Phone (318) _____--_____
*FAX (318) ____ - _____

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:

- ☐ Educational Records
  - ☐ IEP ☐ Evaluation ☐ FBA/BIP
- ☐ Psychological Evaluation
- ☐ Recommendations
- ☐ Medical diagnosis(es)
- ☐ Prescribed medications
- ☐ Discharge summary
- ☐ Other _____

The information is to be released for the purpose(s) of :

- ❑ Evaluation to determine eligibility or continued eligibility for special education services
- ❑ Providing physical therapy treatment
- ❑ Providing occupational therapy treatment
- ❑ Designing an Individual Education Program **(IEP)**
- ❑ Developing an Individual Accommodation Plan **(IAP)**
- ❑ Individualized Health Care Plan **(IHP)**
- ❑ Determining appropriate placement for treatment needs
- ❑ _____

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 **Signature of Parent or Guardian**

Return to: _____ _____
Signature of Student (if 18 years of age or older)

_____ _____
Witness

_____

ATTN: _____