Office of Special Education & Supports · 125 South Clark Street, Suite 800 · Chicago, Illinois 60603
Telephone: 773-553-1800

AUTHORIZATION FOR RELEASE AND USE OF PROTECTED HEALTH INFORMATION RECORDS

_____ _____ _____
Student Name Student ID# Date of Birth

_____ _____
Home Address Home Phone #

I, _____ hereby authorize _____
Parent/Guardian Insert name of individual authorized to disclose records

_____ _____
Address Phone Number

to release my child's medical records to Chicago Public Schools and allow my child's physician/hospital/clinic/agency to communicate directly with the school nurse and other Chicago Public School staff as necessary to address all school-related medical needs, which include but are not limited to, coordination of school health services, development of Individual Education Program or Section 504 Plan health related accommodations and/or individualized health plans and emergency action plans.

Specific information to be released (check all that apply):

- ☐ Medical Records from (insert date) _____ to (insert date)_____
- ☐ Medical Records regarding treatment for the following condition or injury_____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referral, consults, billing record, insurance records and records sent to you by other health care providers, including: (*Indicate by Initialing*)
  - ☐ Alcohol/Drug Treatment
  - ☐ Mental Health Information
  - ☐ HIV Related Information
- ☐ Other:_____

This authorization for disclosure is valid for one calendar year and will expire on _____(Date). If I am authorizing the release of HIV related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the Chicago Public Schools or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the Chicago Public Schools, may not be protected by the Health Insurance Portability and Accountability Act (HIPPAA) privacy provisions, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their contents.

_____ _____
Signature of Consenting Party* Date

_____ _____
Witness (Person Identifying Consenting Party) Relationship

*Student signature is required if the minor student is over 12 years old and if this authorization is for the release of mental health records.

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