AUTHORIZATION FOR RELEASE OF INFORMATION

Missoula County Public Schools
Special Services
909 South Ave. West
Missoula, MT 59801
(406)728-2400 ext. 1087

Student Name: _____
(Last Name) (First Name) (Middle)

Date of Birth: _____Social Security Number: _____

Address: _____
(P.O. Box/Street) (City) (State) (Zip Code)

Home Phone Number: _____Cell Phone Number: _____

I authorize Missoula County Public Schools to: ☐ **RELEASE** ☐ **RECEIVE**
the following information:

- ☐ All medical records
- ☐ Only Medical Records From: _____ (Specific Health Care Provider)
- ☐ Educational
- ☐ Special Education Records
- ☐ Transcripts
- ☐ Psychological (including testing data)
- ☐ Other_____

Information to be released from: _____

Address: _____
(P.O. Box/Street) (City) (State) (Zip Code)

Fax Number: _____Telephone Number: _____

Send Information To: _____

Address: _____
(P.O. Box/Street) (City) (State) (Zip Code)

Fax Information _☐_Yes _☐_No **Fax Number**: _____ (maximum 15 pages)

Purpose of Disclosure: _____

The medical record includes all health care information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all health care information in your/our possession, whether generated by you/us or any other source, as well as health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, and HIV status and/or diagnosis of AIDS and/or other sexually transmitted diseases including hepatitis.

Provision of educational services and treatment are not contingent upon receipt of requested information. The records released to Missoula County Public Schools become part of the student's file. A parent, guardian or the student (upon reaching the age of 18) has the right to view and/or receive a copy of the contents of the file.

I understand that this authorization may be revoked by me at any time, provided I do so in writing and submit it to MCPS up to the extent that the disclosure has not already been made. I also understand that my protected information may be redisclosed by the recipient and no longer be protected under federal law. Information received by MCPS will be subject under FERPA regulations.

_____ _____ _____
Signature of parent/guardian/self (if 18 or over) Date Expiration Date
(12 months unless otherwise specified)