

WILLMAR SCHOOL DISTRICT

611 SW 5th Street
Willmar, MN 56201

Authorization for Release of Protected Health and/or Private Information Consent to Obtain and/or Exchange of Information

Child's Name: _____

Birth Date: _____

School: Willmar Public Schools

Grade: _____

I Authorize the Willmar School District

TO: _____ DISCLOSE; _____ OBTAIN FROM; X _____ EXCHANGE FROM

Name of Organization and Individual: Prairie Lakes Youth Programs

Mailing Address: _____

City/State/Zip: _____

Telephone #: _____

Fax #: _____

The information obtained/exchanged is:

_____ **Most Current**

X _____ **For ALL Service Dates**

_____ **Service Dates From** _____ **to** _____

Check all that apply to request.



School Records/Reports/Transcripts



Chemical Dependency Evaluation & Records



Psychological/Psychiatric Evaluations



Medical Information (including history, physical reports and consultations)



Special Education Records



Psychiatric Reports



Teacher, Counselor, Staff Observations



Social Service Records/IFCSP



Court Services Records/Probation Information



Rule 79 Diagnostic Assessment



Others (*specify*): Phone Conversation

The information requested/exchanged is needed for the following purpose(s):

X To determine the educational and mental health needs of the student and if eligible, formulate the appropriate educational/mental health service plan.

_____ To effect a continuum of care for the client's recovery.

_____ Evaluation/Treatment

_____ Financial/Billing

_____ Per Client Request

_____ Other _____

THIS AUTHORIZATION FOR RELEASE OF INFORMATION SHALL REMAIN IN EFFECT UNTIL THE FOLLOWING DATE AND IS EFFECTIVE ON THE DATE I SIGN IT: _____
_____ (one year from date of signature maximum)

I UNDERSTAND THAT:

1. I understand that this authorization may be revoked at any time. This authorization remains in effect unless it is specifically revoked by written notice to ATTN: Melissa Wilson, Director of Special Education, 611 SW 5th Street, Willmar, MN 56201. I understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. I understand that the revocation will not apply to information that has already been released in response to this authorization or to my insurance company as the law provides the insurer with the right to contest a claim under my policy.
2. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I do not need to sign this authorization to receive services unless the services are court ordered or are to be provided solely for the purpose of creating protected health information or private information for disclosure to a third party (i.e., consultations).
3. I understand that I have the right to inspect and receive photocopies of health information disclosed under this authorization.
4. I understand that if the individual or organization that receives this information is not a health care provider or health plan covered by federal privacy regulations under Public Law #104-191, 1996, the information described in this authorization, may be re-disclosed and no longer protected by the same federal regulations. If I have questions about disclosure of my health information, I can contact the Southwest/West Central Service Cooperative.
5. I understand that a photocopy or facsimile copy of this authorization is as effective as the original.
6. I understand that this information may include chemical dependency information.
7. I also give my permission to exchange information by use of facsimile, email, or United States Postal Service.
8. I have approved the release of records prepared prior to and after the date of signature.

Parent/Legal Guardian/Client Signature

Date

Address

Phone #

**If an individual is unable to sign, a witness signature is required along with the date of that signature and the person's relationship to the client.

Witness Signature

Date

Relationship to Client