# 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:** County Social Worker
**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
- ☑ Psychological/Psychiatric Evaluations
- ☑ Special Education Records
- ☑ Teacher, Counselor, Staff Observations
- ☑ Court Services Records/Probation Information
- ☑ Others (*specify*): Phone Conversation
- ☑ Chemical Dependency Evaluation & Records
- ☑ Medical Information (including history, physical reports and consultations)
- ☑ Psychiatric Reports
- ☑ Social Service Records/IFCSP
- ☑ Rule 79 Diagnostic Assessment

**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