# Name of School

**Street**

**City, State, Zip**

**Phone Number**

**E-Mail Address**

Medical Release of Information Form

Date:

Student's name:

Student's Date of Birth: / /

I, (parent/guardian) have the authority and do hereby authorize the release of medical records for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(student's name)

 I hereby agree, authorize, and consent that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the School) may

 be provided educational and medical records by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (the Provider) for the

 purpose of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ including but not limited to medical and mental

 health records and psychological and psychoeducational evaluations and reports to from my

 child(dren)’s medical providers. This authorization permits the School to disclose and redisclose

 medical records that have been received by the School from the Provider to those parties involved

 in addressing the assessments required as part of the purpose of this record request.

 I hereby waive the confidentiality of the foregoing records under the Family Educational Rights

 and Privacy Act of 1974, Health Insurance Portability and Accountability Act (HIPAA),

 Maryland medical records statute, and any and all other federal and state laws providing for such

 confidentiality and release the above-named provider and School from the obligation to maintain

 the confidentiality of those records with respect to the use described in this release.

 This authorization shall remain in effect for one year, unless revoked sooner by me in writing. I

 understand that any such revocation becomes effective on the date of receipt of the revocation by

 the provider above and that such revocation will not affect any disclosure made before the

 effective date of the revocation.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Name Printed

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date