

ORLEANS PARISH SCHOOL BOARD

Authorization for Release of Protected Health Information

Child's Name: _____ Date of Birth: _____

Address: _____
City State Zip

Social Security _____ Telephone: _____

I hereby authorize _____ to release the information identified in this authorization form from the records of _____ and provide such information to _____ of Orleans Parish Student Evaluation and Support Services. _____ (address)

Purpose For Which Information Is To Be Used

I understand that this information will be made available to persons directly involved in the educational evaluation of my child. Medical information pertinent to the educational assessment may be included in the included Evaluation Report. A copy of the child's evaluation report will be included in his school cumulative file and will be accessible only to school personnel involved in direct service to your child.

I also understand that my permission to release this information may be cancelled at any time except when the information has already been released. My permission to release this information will expire ____/____/____.

Information To Be Released

The most current information regarding (check information requested)

<input type="checkbox"/> Medical Diagnosis	<input type="checkbox"/> Treatment Plan/Medication	<input type="checkbox"/> Other _____
<input type="checkbox"/> Medical Implications for Instruction and Physical Education	<input type="checkbox"/> Recommendations for OT, PT and Speech Therapy (orders if applicable)	<input type="checkbox"/> Audiological and/or Therapy Evaluation(s) and Progress Notes

The undersigned certifies that he/she is the parent/guardian/representative of the child listed above and has legal authorization to sign on behalf of the person, whether by court order, or by operation of law.

Signature of Parent, Guardian or Custodial Agency

Date