

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

**Dawson County Schools
Department of Special Programs
28 Main Street Dawsonville, GA 30534
706-265-3246 Ext. 1007
Fax # 706-216-5720**

Student Name: _____ DOB: _____ FTE#: _____
Parent(s)/Guardian(s): _____
Address: _____
Home Phone #: _____ Cell #: _____

Information Requested:

- Summary of findings, treatment, recommendations
- Discharge/Release Summary
- Treatment Plan(s)
- Progress Notes (such as behavioral summaries)
- Individual Educational Program
- Establish open lines of communication for the duration of service. (Open lines of communication will mean the sharing of information on the student's progress/problems by telephone contact or personal contact to maintain a continuity of services among agency providers.)
- Other: _____
- Case History
- Medical Record
- Psychiatric Report
- Psychological Report
- Educational Report

I hereby authorize Dawson County School System to obtain/release the information indicated above regarding the above-named student from/to:

Agency/Person: _____ Address, telephone/fax#: _____

ATTN: The purpose of this information is to assist in the planning, development, and implementation of the above-named student's educational program. All information obtained/released will be held strictly confidential and cannot be requested/released without your written consent.

****I understand this authorization includes the release of medical records which may include information regarding Immunodeficiency Virus (HIV), psychiatric and/or drug/alcohol abuse, venereal disease, and/or any other statutory protected disease. This authorization and consent will expire ONE(1) year following the date signed. I understand that I may revoke consent in writing at any time except that action which has been taken in reliance thereon.****

Signature of Legal Parent/Guardian Date Signature of Witness Date

Confidentiality Notice: This facsimile may contain individually identifiable patient health information. The use and disclosure of information contained in this fax are restricted by the Health Insurance Portability and Accountability act of 1996 and is protected under the Privacy Act of 1974. It is intended for the use of the addressee(s) identified above. This faxed material must be destroyed appropriately when its use is no longer required. If the reader of this message is not the intended recipient(s) or the employee or agent responsible for delivering the attached information to the intended recipient(s), please note that any dissemination, distribution or copying of this communication is strictly prohibited. Anyone who receives this communication in error should notify the sender immediately and return the original message to the address on this cover sheet via U.S. Mail.