CLARK COUNTY SCHOOL DISTRICT
AUTHORIZATION FOR RELEASE OF INFORMATION

I. STUDENT'S NAME: ______________________ BIRTHDATE: ____________

ADDRESS: ____

I hereby authorize the use or disclosure of the specific information as described below.

II. I authorize release of the following records (description of specific information to be used or disclosed: i.e., medical records, academic records, or entire record):

III. Reasons for use and/or disclosure:

IV. **Persons/Organizations authorized to make disclosure:**

____
School/Organization/Medical Provider

____
Address

____
City State Zip

Persons/Organization authorized to receive and use disclosed information:

____
School/Organization/Medical Provider

____
Address

____
City State Zip

V. This authorization shall remain in effect from the date signed below until (please check one):

- ☐ Expiration Event (i.e., date of disenrollment): ______________________
- ☐ Specific Date: ______________________
- ☐ One year from the date this authorization is signed.

VI. I understand that this authorization is voluntary and that I may refuse to sign. I understand that any medical provider to whom this authorization is furnished may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign the authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand the information used or disclosed may be subject to re-disclosure by the person(s) receiving it, and may then no longer be protected under HIPAA. The District will maintain the privacy of student education records pursuant to the provisions of the Family Educational Rights and Privacy Act.

VII. I understand that I have a right to revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

VIII. Signed ______________________________
☐ Parent or ☐ Guardian

Date ______________________

Requested by ______________________
Name

☐ School Official ☐ Psychologist
☐ School Nurse ☐ Social Worker
☐ Other ______________________

School ______________________

☐ I authorize release of these records through facsimile transmission (FAX). I understand and agree that should the records be inadvertently transmitted to an unauthorized recipient, through no fault of the sender, I hereby waive any claim against the sender and agree to hold the sender harmless from any and all responsibility for damages, if any, arising from the faulty transmission.

☐ I do not authorize release of records through facsimile transmission (FAX).

INSTRUCTIONS:

1. ALL SPECIAL EDUCATION RECORDS MUST BE REQUESTED AND/OR SENT THROUGH STUDENT SUPPORT SERVICES.
2. Parent, guardian, and/or requesting person are responsible for completion of this authorization.
3. The first portion of Section IV should specify the name and the address of the persons/organization holding the records. The second portion should specify the name and address of the persons/organization to which records are to be sent.

USE THIS FORM WHEN:

Obtaining information from other organizations.
Releasing information to other organizations.
Releasing to parents of 18 year or older student.

COPY DISTRIBUTION:

Original to school or organization holding records.
Canary to parents.
Pink to be filed.