Patient Guide

Authorization to Release Information to School

Patient/Student Information Please Print Legibly OR Place Patient Identifying Label	____ Patient Legal Name ____ Date of Birth
School Contact Information *With **Whom** may PrairieCare share/receive my child's information?*	____ School Name District Number Grade ____ Contact Name (If Applicable) Phone Number ____ Address (street, city, state, zip code) Fax Number
Communication Please check all that apply ***How** will PrairieCare share/receive my information?*	**Direction:** ____ Exchange the information indicated below ____ Receive the information indicated below ____ Release the information indicated below **Method:** ____ Written Communication (Fax, Mail, Secured Email) ____ Verbal communication
Information to be Released and Requested: Please mark all that apply. ***What** is to be released and requested?*	____ Diagnostic/Clinical Information ____ Discharge Summaries & Aftercare Plans ____ Medication Information ____ Recommendations ____ Psychological Test Results (check all that apply): __CPT __WISC-R III __MMPI __MACI __Neuropsychological Testing __ Other Testing: ____ Special Education Records ____ School Records ____ Other: ***Please note that CD/Alcohol information and Reproductive Health Information (including lab results) contained in any records will be redacted prior to sending.***
Purpose of the Release of Information ***Why** is the release needed?*	This information will be used for medical and educational purposes.
Statement of Authorization: Please Review Terms and Conditions to Agreement ***What** is my signature authorizing?*	- I understand that I may revoke this authorization at any time, except to the extent that previous action has been taken in reliance of the Authorization for Release of Information. (Please refer to PrairieCare's **Notice of Privacy Practices** for instructions on how to revoke authorizations or to inspect and/or receive copies of this information.) - A photocopy, electronic version, or fax of this authorization will be treated in the same way as the original. - My signature means that I have read this form and/or have had it read to me and explained in a language that I can understand. - Authorizing the disclosure of this information is voluntary, and I can refuse to sign this authorization without consequence to my treatment, eligibility for benefits, or payment status. - Once authorized information is released, PrairieCare, its employees, and its physicians cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent, and any re-disclosure of that information. -I understand that this authorization remains in effect for one year from the date of signature, or: ____ (Specify date, event, or conditions that cause authorization to expire.)

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Signature of Patient *(Patients 16 and older must personally consent for all mental health records.)* Date

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Signature of Parent/Guardian Relationship to Patient Date