Five Town CSD & MSAD 28
Special Education Department
22 Knowlton Street
Camden, ME Camden, ME 04843
(207) 236-7812 ⋄ FAX (207) 236-7810

Authorization for Release of Information

I, _____, do hereby request and authorize Five Town CSD / MSAD 28 to:
(name of parent or guardian)

☐ release to ☐ obtain from ☐ discuss with

_____ information regarding
(**name and address of agency, physician, or individual)**

_____ _____
(**Student name)** **(Date of Birth)**

This information may include:

☐ Discharge Summary ☐ Medical H & P ☐ Progress Notes ☐ Complete Record
☐ Consultations ☐ Psychiatric Evaluation ☐ Treatment Plan ☐ Intake Evaluations
☐ Diagnostic tests ☐ Other Records _____

☐ I DO ☐ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. If I authorize the release of such information, I understand that it cannot be re-disclosed by a recipient without my specific consent.

☐ I DO ☐ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.

☐ I DO ☐ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of HIV infection or AIDS.

☐ I DO ☐ I DO NOT wish to review such information prior to its release. Review must be supervised.

For purposes of:

☐Educational/Day Treatment Program ☐Ongoing Treatment/Aftercare ☐Coordinate Treatment Efforts

☐ Other (please specify): _____

- This consent has been made freely, voluntarily, and without coercion.
- I was able to ask questions and receive answers about this release.
- I hereby authorize releasing/obtaining of the information as specified above and further understand that those who receive this information cannot disclose it to others without my further consent, unless permitted by Federal or State law.
- I understand that I may revoke this authorization at any time.
- I have been offered a copy of this form.
- This authorization is effective for a period of one year from the date of signing.

NOTE: This release is valid only for the purpose stated. The Five Town CSD / MSAD 28 must obtain my written authorization before releasing any further information to any other agency/individual.

I do hereby release the Five Town CSD / MSAD 28 and this agency/physician/individual from all liability and all claims pertaining to the disclosure of this information when used as authorized.

_____ _____
Signature of parent, guardian, or student **Date**

_____ _____
Witness **Date**