GILES COUNTY PUBLIC SCHOOLS
PERMISSION TO RECEIVE AND RELEASE INFORMATION

I, _____, do hereby grant permission for Giles County Public Schools to release the records of (Student's full name) _____ (Date of Birth) _____ to the following agencies and/or individuals. I further grant permission for these same agencies to release information to Giles County Public Schools. It is understood that this permission includes cumulative and confidential information. This information will allow the agencies to better serve the student and parent/guardian.

(Please check appropriate agencies)

_____ Public School System
_____ Department of Social Services
_____ Department of Rehabilitative Services
_____ Family Assessment Planning Team
_____ Court Services Unit
_____ Head Start (New River Community Action)
_____ New River Community Services
_____ Other _____

Authorization For Release of Medical Information

Regarding (Student's Full Name): _____
Students' Date of Birth: _____

To: (Physician's Name): _____
Physician's Address: _____
_____
Physician's Phone: ( ) _____ Fax: ( ) _____
Description of Information to be Released: _____
_____
Purpose of this Release Information: _____

- The health information authorized for release may be subject to re-disclosure by the recipient and no longer protected by the HIPAA Privacy Rule.
- You have the right to refuse to sign this authorization.
- You have the right to revoke this authorization by completing the revocation statement on the back of this page and returning it to the address listed below.

I authorize the release of information to/from the agencies marked and/or of protected health information as described above to the recipient listed below.

Giles County Public Schools

_____
_____
_____
Phone #: ( ) _____ Fax #: ( ) _____

This authorization will expire in <u>twelve months</u> from the date signed unless otherwise specified:
_____

Signature of Parent or Guardian: _____ Date: _____

Relationship to Student: _____ Phone: _____

To Revoke This Authorization, please complete the back of this form Revocation of Authorization

All blanks must be filled out completely.
Parent/Guardian must receive a copy of the signed authorization.
SB-121 (12-06)

I hereby revoke the authorization given on the other side of this page.

Signed: _____ Date: _____

This revocation will be effective only when we actually receive it at the Giles County Public School address listed on the other side of this page. This will not be effective to the extent that we have already acted in reliance upon the authorization at the bottom of this page.

All blanks must be filled out completely.
Parent/Guardian must receive a copy of the signed authorization.