BOZEMAN SCHOOL DISTRICT #7
PO BOX 520, BOZEMAN, MT 59771-0520

PERMISSION TO OBTAIN AND RELEASE INFORMATION

_____

Name: Last, First, Middle Date of Birth Phone

_____

Street Address City State ZIP

Authorize Records Released To and From:

_____
Name

_____
Street Address

_____
City State ZIP

Records Released To and From:

_____
Name

_____
Street Address

_____
City State ZIP

Type or extent of information to be released: (Check all applicable categories)

____ Medical and/or related health records
____ Psychological evaluations or social work reports
____ Developmental/Learning Disability
____ Individualized education program
____ Laboratory reports
____ Consultations
____ Evaluations and related reports
____ Other _____

Purpose or need for release: _____

This authorization will remain in effect until: _____ or for one year from date signed,
Date

and WILL or WILL NOT apply towards records created after the date of signature.

I understand that information used or disclosed based on this authorization may possibly be redisclosed by the recipient, and/or no longer protected by Federal Privacy standards. I understand that if I agree to sign this authorization, I will be provided with a copy of it. I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision not to sign this authorization. I understand written notification is necessary to cancel this authorization. I am also aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that have already been made in reference to this authorization.

_____ _____
Signature of Patient (including minors 14 and over) Date
(If signed by person other than patient, state relationship to patient)

_____
Signature of parent or guardian