Pershing County School District/Project Aware

P.O. Box 389
Lovelock, NV 89419

Permission for the Release of Records

(Medical/Psychiatric/Drug-Alcohol Abuse/Educational)

Student/Patient Name:_____ DOB_____

Information to be released **from**:

_____

_____

_____

☐ Among agencies ☑ checked on the back

Information to be released **to**:

Attention: *Deborah Pontius, RN School Nurse*

Pershing County School District

P.O. Box 389

Lovelock, NV 89419 FAX: *775 273-1147*

Information to release: I give permission to get each of the following records I have initialed *below*:

___ ☐ Consultation Reports	___ ☐ Immunization Records	___ ☐ Psychiatric Evaluation
___ ☐ Discharge summary	___ ☐ Juvenile Records	___ ☐ Special Education Records Including eligibility determination form
___ ☐ Drug/Alcohol Abuse Info	___ ☐ Medication Records	___ ☐ Treatment Plan
___ ☐ Educational Records/Testing	___ ☐ Psychiatric Diagnosis	___ ☐ Vocational Testing
___ ☐ Health Status Update (attached)	___ ☐ Progress Notes	___ ☐ May communicate regarding health issues
___ ☐ History and Physical	___ ☐ Psychological Test Results	

AND/OR:

___ ☐ **Other:** _____

Reason for Release:

☐ Developing an Individualized Educational Plan or 504 Plan

☐ Deciding eligibility for AWARE Wellness Program

☐ Planning and/or continuing a treatment plan

☐ Case review or updating files-including required school immunization files

☐ Other: _____

CONTINUE ON PAGE 2

Information will be used by employees of: Please check all that apply

☐ FCC: Project Aware	☐ Juvenile Probation (11th Judicial District Youth & Family Services)	☐ Pershing County School District (PCSD)	☐ Other:

Authorization

I understand the following:

- I am allowing the agency listed on the front to communicate with the agencies checked above.
- This permission is good for one (1) year from the date I sign it.
- I can withdraw my permission to share this information at any time. I will need to tell PCSD in writing if I wish to cancel this permission.
- The members in the groups checked above, who have a need to know, may discuss this information. The Privacy Rule requires that this information not be shared with another group or person without my written permission.
- However, I also understand that persons receiving the information *may* unknowingly share the information with others where the Privacy Rule doesn't apply.
- I have right to a copy of this form and to look at the records received (except psychotherapy notes).
- I do not have to give my permission to share these records. If I do not sign, I can still receive treatment and payments from my insurance company.
- I release Pershing County School District, Project AWARE, Juvenile Probation, and their employees from any liability arising from the release of this information.

Signature of Parent or Guardian Or student if 18 or over	Relationship to Student/Patient	Date
_____	_____	_____

COPY

A copy of this Authorization of Release was provided to the Parent/Guardian/Of Age Student on: _____

By: _____ Title: _____