North Panola School District
Office of Special Education
Authorization to Release or Obtain Protected Health Information

Name:________________________________County of Residence__________________________
Sex____________Date of Birth________________Social Security Number:____________________
I,______________________________or, I, as the____
(Name of Client) (Parent/guardian/other judicially authorized representative)
Authorize the North Panola School District to release/obtain my protected health information **to/from:**

(Name of Person and Title or Entity and Address to whom/from whom information will be disclosed/obtained)
I specifically authorize the **release/obtaining** (circle) of health information pertaining to the following:
(Must indicate by initialing and/or describing the amount and type of health information to be obtained/released)
_______Medication Records
_______Medical History and Physical Examinations(s)
_______Physicians' Orders/Notes
_______X-Rays and/or Lab Records
_______Evaluations for psychology, audio logy, education, other (list)______________________________
_______Treatment Plans and Related Revisions, Progress Notes and Summaries for psychology, rehabilitation, education, other (list)____
_______Other____
For the specific purpose of____
If entire health record is requested, indicate specific reason that entire record is needed:

Dates of Service applicable to this authorization: From: ________________ **to:** ________________

- I understand this authorization will be **effective on** ________________and will expire on______________.
- I understand that I have the right to revoke this authorization at any time.
- I understand that to revoke this authorization, I must provide a specific request to revoke the authorization in writing to the North Panola School District Special Education Department.
- I understand that my revocation will not apply to action or nay information that has already been released/obtained in response to this authorization.
- I understand that my authorizing the disclosure/obtaining of this health information is voluntary.
- I understand that I need not sign this form in order to receive treatment.
- I understand that I may inspect or copy information to be used or disclosed as provided for by law.
- I understand that any disclosure of information carries with it the potential for a redisclosure and that the information may no longer be protected by federal confidentiality laws. If I have questions about disclosure of my health information.

____ ____________________
(Signature of Individual/Parent/Guardian/Judicially Authorized Representative) (Date)

____
Attach or include description of such representative's authority to act for the client/individual, if applicable.)

____ ____________________
(Signature of Witness) (Date)

Note to Person(s) Receiving Information addressed in this authorization:
This information has been disclosed to you from records, the confidentiality of which is protected by state and/or federal law(s) or regulations. These laws/regulations prohibit you from making further disclosure of this information without the specific written authorization/consent of the person to whom it pertains or of other persons as permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

Center staff must provide a copy of the signed authorization to the client/individual and/or judicially authorized representative.