Sheffield-Sheffield Lake City Schools

Department of Student Services
1824 Harris Rd., Sheffield, OH 44054
Phone: (440) 949-4210 Fax: (877) 664-4354

Authorization Release Form

This authorization is required by the Health Insurance Portability & Accountability Act (HIPAA) of 1996 to inform you of your rights for privacy with respect to your health care information. It authorizes **Sheffield-Sheffield Lake City Schools**:

☐ Release records to, relating to ☐ Obtain records from, relating to

Student Name:	DOB:
Individual/Agency Name:	
Phone:	FAX:

Information to be **released**: (please check)

☐ Academic Records ☐ Behavioral Records ☐ IEP/ETR/Sect 504 Docs ☐ Dates of Attendance
☐ Attendance Records ☐ Referral for new service ☐ Consultation with agency for referral/continuity of care
☐ Records request for coordination/continuity of care ☐ Other: ______________________________

Information to be **obtained**: (please check) ☐ Initial Assessment ☐ Treatment Plan(s)
☐ Progress Notes ☐ Therapy Notes ☐ Medication List ☐ Dates of Service
☐ Compliance ☐ Termination/Discharge ☐ Consultation with agency for continuity of care
☐ Records request for coordination/continuity of care ☐ Other: ______________________________

This authorization is in effect until ____

- I consent to this authorization release designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug abuse (42 CFR Part 2), and/or HIV/AIDS test results or diagnoses (ORC3701.24.3).
- Under the privacy rules I have the right to revoke this authorization at any time in writing and Sheffield-Sheffield Lake City Schools must cease using this authorization. However the practice may complete any action it initiates with my PHI prior to my revocation which rely on the above records for completion. (For example: an insurance company relying on the record to contest a claim).

Student Signature (if applicable)____ Date ____________________

Guardian Signature ________________________________Relationship to patient _____________Date ________

Witness Signature ____ Date ____________________

STOP HERE UNLESS YOU ARE REVOKING AN ALREADY SIGNED RELEASE

☐ I am revoking an already signed Authorization above

Signature _________________________________Relationship to patient _____________Date ______________

Witness Signature ____ Date ____________________