AUTHORIZATION TO RELEASE MEDICAL AND/OR MENTAL HEALTH INFORMATION TO COLORADO SPRINGS SCHOOL DISTRICT 11

Exhibit IHBF-E-2
Reviewed November 14, 2018

PROVIDER:

PATIENT:
ADDRESS:

SS#:
DOB:
PREVIOUS NAME:

1. If requested by Colorado Springs School District 11, I request and authorize the above-named health care or mental health care provider to release information specified below to Colorado Springs School District No. 11 (District).

2. I understand that the information to be released may include information regarding the following condition(s):
   - ☐ Drug abuse, if any.
   - ☐ Alcoholism or alcohol abuse, if any.
   - ☐ AIDS or HIV, if any.
   - ☐ Psychological or psychiatric conditions, if any.

3. INFORMATION REQUESTED:
   - ☐ Copy of provider's complete office and treatment charts including all correspondence, test results, notes, reports, and billing records.
   - ☐ Copy of all outpatient and ER records.
   - ☐ Copy of complete inpatient record.
   - ☐ Other (specify):_____
     _____
     _____

   DATES COVERED:
   - ☐ All admissions or care
   - ☐ Limited to treatment dates or conditions (specify): _____
     _____

4. Purpose(s) or need for which the information is to be used:
   ☐ Educational Services. ☐ Insurance claim. ☐ Damage claim or evaluation.

5. AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it, and that I may contact Colorado Springs School District No. 11 staff for instructions on revoking. This authorization may be used or reused to obtain subsequently prepared records pertaining to educational services or treatment of any type after the date of this release as long as this authorization remains valid. This authorization shall be valid for one year from the date of my signature. I understand that when this information is released it may no longer be protected by the HIPAA Federal Privacy Regulation but will be protected by FERPA and District records policies JRA/JRC and corresponding regulations. I also certify that treatment, payment, or eligibility for benefits were not conditioned on my signing this authorization.

6. OTHER CONDITIONS: ☐ A copy or facsimile of this authorization may be used with the same effectiveness as the original.

X_____ _____
PARENT OR GUARDIAN DATE

_____
(Print name. If not the patient/student, state how authorized.)