

# Sumner County Schools

## Release of Information for Section 504

Student: \_\_\_\_\_

DOB: \_\_\_\_\_

I hereby authorize the release of the following specific information: (Check all items)

YES	NO	NEED:
		1. Medical History, examinations, laboratory tests, and treatment reports
		2. Psychological test/psychiatric evaluation/neurological workup
		3. Summary of previous mental health treatment
		4. Periodic reports of current treatment progress including attendance.
		5. Diagnosis and psychiatric evaluation
		6. Other:

**From:** School: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Attention: Section 504 Designee, \_\_\_\_\_

Email Address: \_\_\_\_\_

**To:** Health Care Provider \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### **Parent or Guardian authorization:**

I understand this shared information will be used only for educational planning. Furthermore, I understand this information will not be disclosed to any other agency or individual without my written authorization except as allowed by law. I understand the protected educational/health information, which is disclosed with this release, may be subject to redisclosure by the recipient and no longer protected by law. I understand Sumner County Board of Education is not responsible for any alterations made on its medical record copies which have been released. In addition, I understand I have a right to a copy of this authorization after I sign it, and this authorization automatically expires one (1) year from date signed.

This authorization for **Release of Information** is given freely, voluntarily, and without coercion.

\_\_\_\_\_  
**Parent/Guardian Signature and Date**

\_\_\_\_\_  
**Student Signature and Date**