PERMISSION TO RELEASE OR EXCHANGE INFORMATION
Portland Public Schools

CLEAR FORM

Date_____

STUDENT NAME_____ **BD**_____ **PPS ID#** _____

SCHOOL_____ **GRADE** _____

As Parent/Guardian/Surrogate Parent or Adult Student (circle one), I authorize the release and exchange of confidential information between Portland Public Schools and:

Name/Agency/Suggested Contact	Telephone/Fax	Address, City, State, Zip
	Tel: Fax:	

The disclosure is to be used for the following purposes:

- ☐ To support student's educational needs
- ☐ To determine special education needs
- ☐ Alcohol and drug evaluation and/or treatment for a student, and referrals to school/other services
- ☐ Mental health evaluation and/or treatment for a student, and referrals to school/other services
- ☐ Medical and health needs
- ☐ Program evaluation
- ☐ Other
  (specify):_____

Please enter fields in English version. They will auto-fill in the Chinese translated form. Ask parties to sign both pages. Send both pages to agency. (The text in this box will not print.)

Information released will include the following specific records:

- ☐ Student Information (may include student's name, address, telephone listing, photograph, date and place of birth)
- ☐ Academic Information
- ☐ Attendance Information
- ☐ Family Background Data
- ☐ Psychological Reports
- ☐ Psychoeducational Reports
- ☐ Social Work Reports
- ☐ Medical Information and Reports
- ☐ Individualized Education Program (IEP)
- ☐ Attendance at Meetings or Appointments
- ☐ Discipline Data (referrals, suspensions, expulsions)
- ☐ Recommendations and Referrals
- ☐ Alcohol/Drug Information and Reports
- ☐ Mental Health Information and Reports
- ☐ Other (specify): _____

The District reserves the right to charge for the costs of providing records. The authorization is valid for two years unless otherwise specified. HIPAA requires that the school district/EI/ECSE program give a copy of the authorization form to individuals who sign it and request a copy.

I hereby approve the release of information as indicated above. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. Any records containing drug and alcohol information maintained by the Agency or the District are additionally protected under the provisions of 42 CFR Chapter 1, Subchapter A, Confidentiality of Alcohol and Drug Abuse Patient Records and may not be further disclosed without specific authorization for such disclosure. By my signature, I hereby, knowingly and voluntarily authorize the above named agency/provider to use or disclose this information, including health information, in the manner described above. I may revoke this authorization in writing at any time. Such revocation may not be retroactive.

x _____
Parent/Guardian/Surrogate/Adult Student Date

_____
Please Print Name

Student signature is ONLY required when requesting mental health or alcohol/drug related information for a student who is 14 years of age or older.

x _____
Student Date

_____
Please Print Name

Authorization expires on _____(month/day/year)**, not to exceed two years from date of signature(s) above**

Please Send Records to:
Portland Public Schools or Department _____

Staff Name/ Title _____

Address, City, State, Zip _____

Phone _____ Fax _____

PERMISSION TO RELEASE OR EXCHANGE INFORMATION
(准许披露或交换信息) 波特兰公立学

CLEAR FORM

日期_____

学生姓名_____ 生日_____ **PPS 学生证#**_____

学校_____ **年级** _____

作为家长/监护人/代理家长或成人学生(圈一个), 我授权波特兰公立学校和以下列出的单位或个人之间披露和交换保密信息:

姓名/机构/建议的联络人	电话/传真	地址, 城市, 州, 电子邮件号码
	电话: 传真:	

Please enter fields in English version. They will auto-fill in the Chinese translated form. Ask parties to sign both pages. Send both pages to agency. (The text in this box will not print.)

披露被用于以下目的:

- ☐ 以支持学生的教育需要
- ☐ 以确定特殊的教育需要
- ☐ 对一个学生的酒精和药物的评估和/或治疗, 并且转介给学校/其他服务
- ☐ 对一个学生的心里健康评估和/或治疗, 并且转介给学校/其他服务
- ☐ 医疗卫生需求
- ☐ 项目评估(Program evaluation)
- ☐ 其它

(请注明):_____

公布的信息将包括以下具体记录:

- ☐ 学生信息(包括学生的姓名, 地址, 电话名单, 照片, 出生的日期和地点)
- ☐ 学业信息
- ☐ 考勤信息
- ☐ 家庭背景资料
- ☐ 心里状况报告
- ☐ 心里教育报告
- ☐ 社会工作报告
- ☐ 医疗信息和报告
- ☐ 个人化教育方案(IEP)
- ☐ 出席会议或预约信息
- ☐ 惩罚记录 (转介, 停学, 开除)
- ☐ 建议及推荐
- ☐ 酒精/药物的信息和报告
- ☐ 心里健康的信息和报告
- ☐ 其它 (请注明): _____

学区保留收取提供记录费用的权利. 该授权有效期为两年, 除非另外指明. HIPAA 要求 school district(学区)/EI/ECSE program(项目)给予签名的并要求复印件的人一份授权表格的副本.

我准许上述信息的公布. 我已经阅读和理解了本授权书的条件并且我有机会询问关于我的健康信息的使用及披露问题. 任何含有药品和酒精信息, 由机构或学区保管的记录额外地受条款 42CFR, 第一章, A 小节, Confidentiality of Alcohol and Drug Abuse Patient Records(酒精和药物滥用患者记录的保密)保护, 并对此信息没有具体授权不能做进一步披露. 由我的签名, 我在此, 知道并自愿授权上述指名的机构/提供者使用或披露此信息, 包括健康信息, 按以上所陈述的方式. 我可以在任何时候撤消这个书面授权. 该撤消可能没有追溯效力.

x _____
家长/ 监护人/代理家长/成人学生 日期

_____
请用印刷体写姓名

当要求一个 14 岁以上学生的与其心里健康或酒精/药品相关的信息时, 仅需要学生签名.

x _____
学生 日期

_____
请用印刷体写姓名

授权过期于 _____(月/日/年)**, 从上述签名的日期起不超过两年**

请寄报告给:

Portland Public Schools or Department(波特兰公立学校或部门) _____

职员姓名/称号 _____

地址, 城市, 州, 邮编 _____

电话 _____ 传真 _____