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):_____

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 _____