



**PERMISSION TO RELEASE OR EXCHANGE INFORMATION**  
Portland Public Schools

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:<br>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 \_\_\_\_\_



**OGOLAASHA SIIDAYNTA IYO IS-DHAAFSIGA MACLUUMAADKA**  
Dugisyadda Guud ee Portland

Taariikhda \_\_\_\_\_

**MAGACA ARDAYGA** \_\_\_\_\_ **BD** \_\_\_\_\_ **PPS ID#** \_\_\_\_\_

**DUGSIGA** \_\_\_\_\_ **FASALKA** \_\_\_\_\_

Waalidka/Hagaha/Waalidka Badiilka ah ama Ardayga (fadlan calaame mid un, Waxaan ogolaaday sii daynta iyo in ay kala bedelashaan macluumaadka qarsoodiga ah Dugisyadda Guud ee Portland iyo:

| Magaca/Ururka/Lala Xidhiidhaha | Telephone-ka/Fax-ka | Ciwaanka, Magaaladda, Gobolka, Astaanta(zip) |
|--------------------------------|---------------------|--|
|                                | Tel-ka:<br>Fax-ka:  |  |

Sii daynta macluumaadkan waa in loo adeegsado ujeedooyinkan:

- In laga caawiyo ardayga baahiyadda waxbarasheed
- La ogaado baahida ardayga ee waxbarashadda gaadhka ah
- Qiimaynta aalkoladda iyo daroogadda iyo/ama dawaynta ardayga, iyo duwidda dugsiga/adeegyadda kale
- Qiimaynta dhimirka iyo/ama dawaynta ardayga, iyo duwida dugsiga/adeegyadda kale
- Baahida caafimaad iyo Dawadda
- Qiimaynta barnaamijka
- Kuwa kale (Tilmaan): \_\_\_\_\_

Macluumaadka la siidaynayo waxaa ku jira kuwa gaadhka ah ee soo socda:

- Macluumaadka ardayga (marka lagu daro magaca ardayga, cinwaanka, telephone-ka, sawirka, taariikhda iyo goobta dhalashadda)
- Macluumaadka akadeemiyadeed
- Macluumaadka xaadiridda
- Soyaalka Qoyska
- Warbixinnadda nafsiyadeed
- Warbixinadda shakhsiyadeed ee barashadda
- Warbixinta adeegaha bulshadda
- Macluumaadka caafimaad iyo warbixinadda
- Barnaamijyadda gaadhka ah ee waxbarashadda (IEP)
- Xaadiridda Kulamadda ama Balamaha
- Macluumaadka Anshaxa (duwida, xanibidda, eryidda)
- La talinta iyo Duwidda
- Macluumaadka Aalkoladda/Daroogadda iyo warbixinnadda
- Mental Health Information and Reports Caafimaadka dhimirka iyo Warbixinadda
- Kuwa kale (Tilmaan): \_\_\_\_\_

Degmadu waxay la keli noqonaysaa xuquuqda in ay kharash ku dalacdo biixnta macluumaadkaa. Ogolaashuhu waxaa jiri karaa laba sanadood hadii markaa aan la cadaynin. HIPAA waxay ka doonaysaa degmadda barnaamijyadda /EI/ECSE in ay siiyaan nuqul warqadda ogolaashaha ah qofkii saxiixa islamarkaana codsadda nuqul.

Waxan qirayaa in aan ogolaaday bixinta macluumaadka xagga sare lagu xusay. Waan akhriyey oo gartay waxa uu ka koobanyahay ogolaashahan waanan helay fursad aan ku waydiiyo wixii su'aalo ah ee la xidhiidha siidaynta macluumaadka caafimaadkayga, macluumaad walba oo ka kooban aalkoladda iyo daroogadda oo ay adeegsadeen hay'adda ama degmadu waxaa udheer in lagu ilaaleeyey qaanuunka 42 CFR qaybtiisa 1, faqradda A, qarsoodiga la xidhiidha bahdaladda Daroogadda iyo Aalkoladda way xafidanyihiiin lamana sii dayn karo iyadii oo aan ogolaasho gaadh ah oo ku jeeda taa aan la helin, islamarkaana aan anigu ku saxiixanahay, waxaan ogolaaday, aniga oo og cid igu qasabtayna aysan jirin hay'adaha/adeeg bixiyaha xagga sare lagu xusay in ay adeegsadaan ama ay sii daayaan macluumaadkan, marka lagu daro macluumaadka caafimaadka ee ubadka xagga sare lagu. Waxaan ka laaban karaa ogolaashahan iyadii oo qoraal ah goor walba. Ka laabashadda dib looma cusboonaysiin karo

x \_\_\_\_\_  
Waalidka/Hagaha/Waalidka Badiilka ah ama Ardayga \_\_\_\_\_ Taariikhda \_\_\_\_\_

Fadlan Qor Magaca \_\_\_\_\_

Saxiixa ardayda waxa la doonayaa oo keliya marka la codsanayo caafimaadka dhimirka ama macluumaadka la xidhiidha aalkoladda/daroogadda ardayga da'diisu gaadhay 14 sanno iyo wixii ka wayn.

x \_\_\_\_\_  
Ardayga \_\_\_\_\_ Taariikhda \_\_\_\_\_

Please Print Name \_\_\_\_\_

**Ogolaashuhu waxa uu ku egyahay \_\_\_\_\_ (bisha/maalinta/sanadka), ma dhaafayo in ka badan labo sanno min maalinta ku dhigan saxiixa xagga sare lagu qoray**

**Fadlan udir:**  
Portland Public Schools or Department \_\_\_\_\_  
Staff Name/ Title \_\_\_\_\_  
Address, City, State, Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_