



MEDICAL/EDUCATIONAL
INFORMATION REQUEST
DEKALB COUNTY SCHOOL DISTRICT
SECTION 504/HHB



Student Name:

Date of Birth:

Student Address:

Phone:

School:

Parent/Guardian:

I hereby authorize a release of information as identified between DeKalb County School District Staff and the individual(s) indicated below concerning the above named student:

- | | | | |
|---------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Rheumatologist | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Ophthalmologist/Optomtrist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Speech-Language Pathologist | <input type="checkbox"/> Educational Consultant | <input type="checkbox"/> Other: |

Releasing doctor/clinic information:

Releasing doctor/clinic information:

Name _____
 Address _____
 City/State/Zip _____
 Phone _____ Fax _____
 Type of Records Needed _____

Name _____
 Address _____
 City/State/Zip _____
 Phone _____ Fax _____
 Type of Records Needed _____

Releasing doctor/clinic information:

Releasing doctor/clinic information:

Name _____
 Address _____
 City/State/Zip _____
 Phone _____ Fax _____
 Type of Records Needed _____

Name _____
 Address _____
 City/State/Zip _____
 Phone _____ Fax _____
 Type of Records Needed _____

- I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug or psychiatric disorders.
- I authorize the inspection of the above information by the above names agency/person and/or to the furnishing of a photostat or other copies.
- I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information disclosed prior to DeKalb County School District receiving a written notice of withdrawal.
- I hereby release DeKalb County School District and its officers, directors, agents, and employees from any and all liabilities, responsibilities, damages, losses, and claims which might arise from the release of the information authorized above.
- In furtherance of this authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.
- I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily authorize the disclosure of this medical information to the individual or agency named above.

In compliance with the Family Educational Rights and Privacy Act of 1974, these records will be released to Parents/Guardians or Students over 18 years of age upon their request. The granting of consent is voluntary on the part of the parent.

This authorization expires _____ (insert applicable date or event or insert "no expiration designated") or 12 months for school requests whichever is shorter, and no further use/disclosures as described above may be made after the expiration. Authorizations apply only for medical records for specified treatment dates prior to and on the date of signature, unless otherwise specified. Specified exceptions for future-dated releases are: _____

Signature: _____
Parent or Guardian

Date: _____