PORTER TOWNSHIP SCHOOL CORPORATION

PTSC Release of Information Authorization Form

Student/Patient Name: _____ Date of Birth: _____

Send From ☐ Send To: ☐

Porter Township School Corporation (its affiliates, employees, and agents)
248 South 500 West
Valparaiso, IN 46385
Phone: 219-477-4933

Send From ☐ Send To: ☐

Agency: _____(its affiliates, employees, and agents)
Address: _____
Phone: _____
Fax: _____
Attn: (Name and Title): _____

INFORMATION TO BE DISCLOSED: (TYPICAL SCHOOL INFORMATION)

☐ All Pertinent School Records including all of Below:
☐ Transcripts, report cards, attendance reports
☐ School Health Records
☐ RTI Data/General Education Referral
☐ Specialized /Diagnostic Evaluation
☐ Education/Psychological Evaluation/Reports
☐ Discipline and Behavior Records
☐ Other _____

SPECIFIC MENTAL HEALTH/HEALTH AGENCY INFORMATION TO BE RELEASED:

☐ Entire Medical Record including all of Below:
☐ Medical History/Hospitalization
☐ Psychiatric/Mental Health Treatment Records
☐ Summary of Psychiatric Treatment
☐ Psychotherapy Notes
☐ Medication History
☐ Psychiatric Evaluation Results
☐ Mental Disorder/diagnosis
☐ Most Recent Contact Date
☐ Drug/Alcohol Information and/or Abuse Records
☐ Treatment Plan
☐ Clinician's Office Notes
☐ Patient Histories
☐ Test Results
☐ Records Sent to You by Other Health Care Providers

AUTHORIZATION STATEMENTS:

- I authorize the individual health care provider listed on this form to discuss health information with Porter Township School Corporation (its affiliates, employees, and agents).
- I understand that I am not required to sign this authorization but I further understand that failure to grant authorization for the requested information may limit the school's ability to determine eligibility for services and/or develop an appropriate education plan for the student.
- I understand that the records for which I am authorizing release, once received by the school district, may not be protected by HIPAA Privacy Rule, but will become educational records protected by FERPA. As educational records, they may be subject to re-disclosure.
- I understand that this authorization is valid from the date of my/my representative's signature below and shall expire one year from that date, unless I revoke this authorization in writing.
- I understand that I may withdraw or revoke my permission at any time by writing to the PTSC Superintendent, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I further understand that I am entitled to receive a copy of the authorization, if requested, and that a photocopy of this authorization is as valid as the original.
- I release the individuals and/or organization named in this authorization from legal responsibility or liability for the disclosure of the records authorized on this form.

Records will continue to be released, as requested, from the date of signing unless the parent or guardian rescinds this release in writing.

_____ _____

Parent Signature Date

_____ _____

Student Signature (if aged 18 or older) Date