MAINE SCHOOL ADMINISTRATIVE DISTRICT NO. 49

ALBION ~ BENTON ~ CLINTON ~ FAIRFIELD

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

Student's Name: ______________________________ Date of Birth: ____________________

I hereby authorize

______________________________ and ______________________________

(Name of School) (Name of Second Party)

______________________________ ______________________________

(Address) (Address)

to exchange complete records/information on the above named student.

State and Federal laws require my specific consent to disclose any of the following information:

Circle one response for each of the four statements below.

I DO I DO NOT authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. If I authorize the release of such information, I understand that it cannot be re-disclosed by a recipient without specific consent.

I DO I DO NOT authorize disclosure of information which refers to treatment of diagnosis of psychiatric illness.

I DO I DO NOT wish to review this information before it is released. I understand any such review must be supervised.

I DO I DO NOT authorize the disclosure of information which refers to treatment or diagnosis of HIV infection, ARCS, or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.

I understand that:

signing this authorization is not a condition to treatment, payment, enrollment and eligibility for benefits.

I can refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment.

I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated and signed notification to the facility indicated above.

I am entitled to a copy of this authorization, upon request.

I can cross out any provision on this form with which I disagree.

I DO I DO NOT authorize future disclosures regarding these records to the same individuals and/or entities. This authorization is effective until ____________date not to exceed one (1) year.

______________________________ ______________________________

Signature and Relationship Date

Revised 2/1/08