**AUTHORIZATION FOR DISCLOSURE OF**

**HEALTH AND EDUCATIONAL RECORDS AND INFORMATION**

I hereby authorize the release or exchange of health and educational records and information regarding , as follows:

1. By initialing here , I authorize to release copies of my child’s/student’s medical, psychological, psychiatric, and other records to:

Poughkeepsie City School District

Office of Students with Exceptionalities

18 South Perry Street

Poughkeepsie, New York 12601

1. By initialing here , I authorize the Poughkeepsie City School District to release copies of my child’s/student’s educational records to:

1. By initialing here , I further authorize and a representative of the Poughkeepsie City School District, Special Education Office to speak with each other and exchange oral information regarding my child’s/student’s medical, psychological or psychiatric treatment and educational program, services and progress.

1. The purpose for which the information will be used or disclosed is as follows: to evaluate and make recommendations regarding the patient’s/student’s health care and/or educational needs.

1. I understand that I may revoke this authorization in writing at any time, except that such revocation will not affect actions already taken in reliance on this authorization. I understand that, in order to revoke this authorization, I must send a written notice stating my intent to revoke this authorization to the above-named provider and the Poughkeepsie City School District.
2. Except as otherwise permitted or required by law, my treatment, and payment, enrollment in a health plan or eligibility for benefits will not be condition upon my authorization of this disclosure. I understand that, except as otherwise provided by law, my protected health information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by applicable state and federal law governing the confidentiality of medical information.
3. Unless revoked earlier, this authorization will expire (check one):

⬜ On the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

⬜ Upon the following event:

If no expiration date or event is given, it is assumed that the authorization will expire one year after it is signed.

Signature: Date:

 [*Name of Parent or Guardian*]

Relationship to patient/student: