School-Hospital Records Release and Communication Form

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Whom It May Concern:

 I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(your name),** the parent and/or guardian of student, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **(student/patient name),** give **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| HIV Test Results  |
| Genetic Screen Test Results |
| Alcohol and Drug Abuse Treatment Records |
| Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC).  |
| Confidential Communications with a Licensed Social Worker  |
| Information related to a sexually transmitted disease  |
| Information related to diagnosis or treatment of Hepatitis  |
| Information related to diagnosis or treatment of Pregnancy  |
| Information related to spouse abuse and/or child abuse or neglect  |
| Information concerning family violence and/or Domestic Violence Victims’ Counseling  |
| Contain information regarding rape and/or Sexual Assault Counseling  |
| Other(s): Please list  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hospital/clinic name)** to release my child’s protected health and medical record to pilotED Schools: Bethel Park. I understand the information may include the items below:

I hereby authorize my hospital/clinic/health provider to release any medical information. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes.

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Signature of Parent/Guardian Name of Parent/Guardian (Print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient/Student