West Liberty School District

I, the undersigned, authorized the West Liberty School District to deliver and/or disclose student records and information.

Student:________________________________________________D.O.B.____________________

To:

Person and/or Agency__________________________City_________________State____Zip_________

Including: (Check one or both as appropriate)

( ) Any and all information, records, and reports related to: School Attendance, grades, performance, counseling, and behavior, health, family and social date; educational assessment and programming; special education evaluation including psychological, educational, developmental, social, emotional, behavioral testing and assessment; special educational placement, programming, and services; mental health, medical evaluation and treatment; pre-natal exposure to or use of controlled substances, and/or alcohol affecting development or functioning; **(Mark out any of the above not to be disclosed)**

( ) The information indicated (be specific)________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

**For the Purpose of:** (check one or both as appropriate)

( ) Facilitating evaluation and identification of student's educational needs and/or provision of programming and services

( ) Other purpose (be specific):______________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

**I understand that: (Please be sure that you have read and understand this document before signing.)**

I may review any information disclosed and/or withdraw my consent for disclosure at any time. Notice of withdrawal of consent must me sent in writing to the principal and will not apply to disclosures made prior to receipt of notice of withdrawal of consent. Information disclosed prior to withdrawal of consent may be used for the purpose indicated above. This authorization will automatically expire 90 days from the date of signature unless an alternative expiration date is specified in the following blank. Alternative expiration date __/__/__. (Not more than one year from the date of signature.)

Parent Signature:_______________________________________________________Date:__________

Relationship:_____________________________________________________________________

Student Signature:______________________________________________________Date:__________

Required in the case of students 18 years of age or older who are competent to provide informed consent. Though it cannot be required against the wishes of a competent student 10 or older, parent signature should also normally be obtained as long as the student resides in the parent's home, is dependent on the parents, and has not graduated.

Notice to Recipient: Except as permitted by state and federal laws and regulations, the further disclosure in any manner of the records and information disclosed in accordance with the authorization provided by this document and/or their use for purposes other than those of which consent for disclosure was granted is prohibited by law without the written consent of the parent or eligible student.

Form 1989

# CONSENT TO RELEASE OF INFORMATION

Hosp. #: ______________

University of Iowa Hospitals and Clinics (UIHC)

Health Information Management Department, 200 Hawkins Drive, Iowa City, IA 52242
Release of Information Office (Tel 319-356-1719; Fax 319-356-3079)

**Please neatly PRINT (except signature) and provide complete information in each section.**

**Patient's Legal Name** ________________________________________ **Birth Date**__________________________

By signing this form, I am allowing UIHC to release medical information concerning the above named patient to the person or facility listed below. This information may be shared by: Viewing _____ Verbal _____ Copies _____ CD_____ CareLink _____
(Please note, burning to a CD is only possible when transferring electronic information. Copies of paper documents will be provided on paper.)

______________________________________________________________________________
Name of Person and/or Institution who will receive information

______________________________________________________________________________
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

**Check the information to be disclosed (include dates if known):** ____Minimum necessary, or specify as follows:

__ Medication list __ Allergy list __ Immunization record ____ Problem List (Pt. Summary list)
__ History and Physical, specify clinic or date__________________________________________
__ Discharge summary, specify clinic or date__________________________________________
__ Laboratory results, specify type or date__________________________________________
__ X-ray and imaging reports, specify type or date__________________________________________
__ Consultation reports, specify doctor or clinic__________________________________________
__ Test results ( e.g. EKG, PFT, etc.), specify type or date__________________________________________
__ Billing Information, specify__________________________________________
__ Other, specify__________________________________________

**Please check the reason for release below; and provide date by which the info is needed:** ____________________

Insurance _____ 2nd opinion _____ Rehab/disability_____ Personal file _____ Moving out of area _____ Legal _____

Other medical care _____ Transferring care _____**If transferring care,** may we confidentially discuss with you? YES___ NO___

If yes, please indicate the best time and telephone number to reach you: ________________________________________

This Consent is voluntary. If I cancel this consent at a later date, I must send written notification to the Director of Health Information Management at the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address.

UIHC does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services.

I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (***initial*** any category ***not*** to be released).

Substance Abuse ________ Mental Health ________ HIV-related information ________ *Genetic tests/info ________
*Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement will expire two years from the date of signature, or as indicated (specify number of days or months) ____________________________ unless cancelled by the patient/guardian.

______________________________ ______________________ ____________
Signature of Patient or Legal Guardian Printed Name Date

______________________________ ______________________________
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

______________________________ ______________________________
Relationship, if Not the Patient Witness Signature

***UIHC use only:*** *Upon satisfying this release, date & sign; record on the Release of Information Tracking (ROIT) system and scan the form in to Epic.* ***If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, complete the following as appropriate and then forward to the Release of Information Office, Heath Information Management (HIM) Department, 2 SRF.***

Info. sent: ________________________ ____________ Recorded on ROIT System:________________________ ____________
Name/Department Date OperatorName/Department Date

Revised: 1-2014

White Original: Scan in to Epic Copy: Patient