Helena Public Schools
Safe Schools / Healthy Students Initiative

AUTHORIZATION AND CONSENT TO DISCLOSURE AND EXCHANGE OF INFORMATION

Name of Student: _____ DOB: _____

Address: _____ Phone: _____

Name of Parent/Legal Guardian: _____

I hereby consent to and authorize the mutual disclosure and exchange of information and records concerning the above-named student by and between the organizations that I have placed my initials next to below:

_____ AWARE
_____ Benefis Hospital
_____ Big Brothers Big Sisters
_____ Boyd Andrew
_____ Career Training Institute
_____ Catholic Social Services
_____ Center for Mental Health
_____ Child Care Partnerships
_____ East Helena School District
_____ Family Outreach
_____ Florence Crittenton Home
_____ God's Love
_____ Head Start
_____ Helena Food Share
_____ Helena School District
_____ Intermountain
_____ Juvenile Parole / Probation
_____ Kids Management Authority
_____ L&C City County Health Dept.
_____ Montana Youth Homes
_____ Office of Public Assistance
_____ Project SUCCESS
_____ Shodair
_____ St. Peter's Hospital
_____ Teen Screen
_____ Women, Infants & Children (WIC)
_____ YWCA

Other Specific Provider(s)

_____

_____

INFORMATION AUTHORIZED FOR RELEASE / EXCHANGE: (Please place your initials next to the types of records / information that you authorize for release / exchange – Please draw a line through any items that you <u>DO NOT</u> authorize for release / exchange)

___ Medical Records ____ Education Records ____ Drug/Alcohol Assessments

___ Other Client Records (Social Assessments, Demographic Information, etc.)

I specifically authorize the disclosure and exchange of the following specific categories of information, UNLESS the line next to that category of information is checked to indicate that the information SHOULD NOT be disclosed (please place your initials where disclosure / exchange is not authorized)

_____ Do not disclose records of HIV/AIDS testing or treatment;
_____ Do not disclose mental, psychological or psychiatric records;
_____ Do not disclose psychotherapy notes;
_____ Do not disclose alcohol or drug abuse treatment records;
_____ Other restrictions on disclosure (specify): _____
_____

My consent and authorization to this mutual disclosure and exchange of information and records is being granted with the following understandings on my part:

- That this consent and authorization is not valid without the required signature below*;*
- That my consent and authorization is being provided voluntarily, and that it will expire no later than **one year** from the date below unless I revoke it in writing prior to that time;
- That I have the right to revoke this authorization at any time in writing, except to the extent that information may have already been disclosed pursuant to this consent and authorization*;*
- That I have the right to request a copy of this form after I sign it, and may have the right to inspect or copy any information shared or disclosed in accordance with this consent and authorization to the extent allowed for by state and federal law;
- That I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from at least certain of the providers outlined above. I also understand, however, that there may be consequences attendant to a decision on my part to not authorize the disclosure and sharing of information, i.e., that at least some of the organizations listed above may not be able to effectively provide services without it*;*
- That some of the information shared between the organizations listed above may be subject to various state and federal privacy laws, including but not limited to HIPAA, FERPA and/or the alcohol and drug abuse privacy regulations (42 C.F.R. Part 2), and that all of the organizations listed above agree to comply with those regulations to the extent they apply to their respective activities, including but not limited to any restrictions or allowances for the any further disclosure of information shared or provided to them in accordance with this consent and authorization;
- That when certain types of my information are used or disclosed pursuant to this authorization, they may be subject to re-disclosure by the recipient to others without my knowledge or further authorization, in which event applicable privacy laws may no longer protect my information;
- That, to the extent I am authorizing the disclosure of information above that specifically relates to alcohol or drug abuse, the entities to whom such disclosure and sharing has been authorized above ARE PROHIBITED from making any further disclosure of that information to any person or entity outside the group identified above, unless otherwise authorized permitted by 42 C.F.R. Part 2 or they receive express written consent for such further disclosure*;*

_____ Date: _____

Parent/Legal Guardian /Minor Student[1] Signature

_____ Date: _____

Witness

Please check applicable box if signing on behalf of patient and provide a copy of authorizing document for items marked below with an asterisk (*)

□ Parent of minor child □ Legal Guardian* □ Power of Attorney* □ Other Personal Representative*

REVOCATION OF AUTHORIZATION / CONSENT

I hereby REVOKE the foregoing Authorization and Consent to Disclosure and Exchange of Information in its entirety.

_____ Date: _____

Parent/Legal Guardian/Minor Student Signature

[1] Minors are authorized by Montana law (§ 41-1-401, et seq., MCA) to both (1) consent to the provision of health care services and (2) control access to protected health care information under certain limited circumstances (i.e., pregnancy, sexually transmitted disease, or substance and alcohol abuse). Any utilization of this form based on the signature of a minor student should be carefully reviewed by the agency to ensure such circumstances are applicable.