The Arc of Franklin & Fulton Counties
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HIPPA Compliant Authorization for the Release of Patient Information

Program: Educational Advocacy

To: _____
Name of Provider, School, Facility, Physician, or Coordinator

_____
Street Address

_____
City, State, and Zip Code

Re: _____
Minor's Name

_____ _____
Date of Birth Parent/Guardian's Name

I authorize and request the disclosure of all protected information, verbal or written, for the purpose of review and evaluation in connection with a legal claim related to child educational advocacy rights. I expressly request that the designated record custodian of all covered entities under HIPPA identified above disclose full and complete protected information, written or verbally, including the following:

___ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinical records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results statements, questionnaires/histories, photographs, videotapes, telephone messages, and records received by other professionals.

___ All non-medical records, meaning every page in my record, including but not limited to: evaluation reports, IEP records and reports, assessments, office notes, face sheets, history notes, school records to include attendance, disciplinary records, photographs, videotapes, telephone messages, and records received by other professionals and/or educational entities.

I authorize The Arc of Franklin & Fulton Counties to share the information received along with their findings, impressions, and recommendations of the above information for the purposes of Educational Child Advocacy.

I understand that this information will be used for the specified purposes only and will be treated with the utmost confidentiality. Photocopies and faxcimilies of this form shall be considered valid.

_____ _____ _____
Signature Date Relationship

*If under the age of 18, or if a court appointed guardian is applicable – they must sign the form above