Patient Sticker

AUTHORIZATION FOR RELEASE OF SCHOOL RECORDS AND EDUCATIONAL INFORMATION

Please check all applicable boxes in all sections. Please note this is a 2-page form.

INFORMATION TO BE DISCLOSED (CHECK ALL THAT APPLY):

☒ Education Records/Special Education Files ☒ Psychological/Neuropsychological Evaluations
☒ Immunization Records ☒ Consultations (Physical Therapy, Speech/Language Therapy, Occupational Therapy)
☒ Statement of Psychiatric Diagnoses for Special Education Purposes if required ☒ Master Treatment Plan
☒ To allow school district personnel participation in and/or attendance at treatment team meetings

Purpose: This information will be used to facilitate educational services for the patient. Please indicate the three most recent schools the patient has attended prior to Shodair Children's Hospital.

1. Name of Most Recent Home School/School District

Shodair Hospital may request above protected healthcare information from this provider ☒YES ☐ NO
Shodair Hospital may disclose above protected healthcare information to this provider ☒YES ☐ NO

Name____

Address____

City____________________ State____________ Zip__________

Phone ____________________ Fax ____________________

2. Name of Previous Home School/School District

Shodair Hospital may request above protected healthcare information from this provider ☒YES ☐ NO

Name____

Address____

City____________________ State____________ Zip__________

Phone ____________________ Fax ____________________

3. Name of Previous Home School/School District

Shodair Hospital may request above protected healthcare information from this provider ☒YES ☐ NO

Name____

Address____

City____________________ State____________ Zip__________

Phone ____________________ Fax ____________________

This authorization will remain valid for a period of 12 (twelve) months from date of signature unless revoked before that time as described below. I understand that this authorization for release of information may be revoked at any time by sending such revocation in writing to the HIM Director at 2755 Colonial Drive, Helena, MT 59601. Shodair will comply with the revocation unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization. Leaving treatment at Shodair against medical advice does not, in and of itself, constitute a revocation of this authorization for release of information.

Shodair Hospital may not condition treatment or payment on whether an individual signs this authorization. The potential exists for information disclosed pursuant to this authorization to be re-disclosed by the recipient and no longer be protected by federal law. The undersigned person(s) agree to indemnify and hold harmless Shodair Hospital and its employees from all claims or liability that may arise as a result of Shodair's compliance with this authorization.

____________________________ ____

Date Signature of Parent/Legal Guardian (Circle Applicable Status)

____________________________ ____

Witness Print Name of Patient DOB

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 C.F.R.) Part 2 prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of the first offense and not more than $5,000 in the case of each subsequent offense. FD:6/15 EDUCATION ROI REV: 5/18