

**MARSHALL  
PUBLIC SCHOOLS**

Marshall Public Schools  
ATTN: School Nurse  
401 S. Saratoga Street  
Marshall, MN 56258  
507--537-6920 tel  
507-537-6933 fax

**Instructions:**

Insert information in the blank spaces below. This request will be returned and records will be delayed if incomplete information is given. Call 507-537-6920 with any questions.

**AUTHORIZATION FOR  
RELEASE OF INFORMATION – FOR USE WITH HIPAA COVERED ENTITIES**

|  |  |  |  |
|--|--|--|--|
| <b>Student/<br/>Patient:</b>   | Name   | Previous Last Name (if any)  | Medical Record #   |
|  | Address  |  | Day Phone No.  |
|  | City   | State  | Zip  |
|  | Date of Birth  | Social Security Number   |  |
| <b>Which provider has the information you would like released?</b>   | Name   | Organization   | Phone No.  |
|  | Address  |  |  |
|  | City   | State  | Zip  |
| <b>To whom should the information be sent?</b>                       | Name   | Name of School   | Phone No.  |
|  | Address  |  |  |
|  | City   | State  | Zip  |
| <b>Information to be disclosed:</b>                                  | <b>DESCRIPTION OF RECORDS TO BE RELEASED</b>   |  |  |
|  | Records Concerning: _____<br>Specific Diagnosis or Treatment and Specific Dates of Service   |  |  |
|  | <input type="checkbox"/> Clinic visit notes<br><input type="checkbox"/> Lab Reports<br><input type="checkbox"/> Consultation/Follow-up Reports   | <input type="checkbox"/> Human Service Records<br><input type="checkbox"/> Medical Records<br><input type="checkbox"/> Psychiatric/<br>Psychological Records | <input type="checkbox"/> Chemical Abuse/<br>Dependency Records<br><input type="checkbox"/> Other |
| <b>No Conditioning Treatment, Payment, Enrollment or Eligibility</b> | The above-named provider may not withhold treatment, payment, enrollment, or eligibility for benefits if I do not sign this form.  |  |  |
| <b>Purpose for the Release</b>                                       | <input type="checkbox"/> Special Education Evaluation<br><input type="checkbox"/> Section 504 Evaluation   | <input type="checkbox"/> At request of parent/eligible student   | <input type="checkbox"/> Other (Specify)   |
| <b>Right to Revoke</b>   | I understand that this authorization will be in effect for 12 months from the date signed unless this authorization is revoked by me. I understand that I may revoke this authorization by providing written notice of revocation to the above-named provider, who is bound by the request to revoke if the information requested in this authorization has not been provided. I understand that I may revoke this authorization in accordance with instructions contained in the school district's notice of privacy practices. |  |  |
| <b>Authorization</b>   | I authorize the above-named provider to release the information described above. I understand that upon release, this health information may no longer be protected by federal health care privacy rules. However, other state and federal laws governing the disclosure of educational data may prohibit the redisclosure of such information without first obtaining an additional authorization.  |  |  |
|  | <b>Signature</b>   |  | <b>Date</b>  |
|  | <b>If other than student/patient, please describe authority to act for the student/patient.</b>  |  |  |
|  | If person signing is a parent: My authorization is based on my capacity and authority as a custodial parent.   |  |  |
| <b>Right to a copy</b>   | I have read this information. I have received a copy of this signed authorization.   |  |  |