ADAMS-WELLS SPECIAL SERVICES

925 North Main Street
Bluffton, IN 46714
Phone 260-824-5880 Fax 260-824-8654

Student's Name: _____ Date of Birth: ____/____/____

Current Grade: _____ School Attending: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize the agency below to disclose and share to Adams Wells Special Services information as indicated below:

(FROM: Name of person and/or organization to which disclosure is to be sent) (relationship)

Attention: _____ Phone Number: _____ Fax Number: _____

To: Adams Wells Special Services Cooperative 925 North Main Street Bluffton, Indiana 46714

Attention: _____ Phone Number: **260-824-5880** Fax Number: **260-824-8654**

Please INITIAL next to ALL checked information. (invalid without initials)

Date(s) of Treatment/Services to Release: _____

- ____ Assessment/Psychiatric Evaluation
- ____ Attendance Documentation
- ____ History and Physical Examination
- ____ Lab Results
- ____ Medication(s)
- ____ Educational Testing
- ____ Exchange Information
- ____ Progress Notes
- ____ Psychological Test Results
- ____ Transfer/Termination Summary
- ____ Treatment Plan
- ____ Other: _____

The purpose of the disclosure authorized above is: (check specific purposes(s) for disclosure)

- ____ School Evaluation
- ____ To Provide Information to Physician
- ____ Other: _____
- ____ Respond to Request for Information
- ____ For Permission to Return to School

I understand that the information used or disclosed may be re-disclosed by the person receiving it and is no longer protected by the Federal Health Information Portability and Accountability Act (HIPPA, 45 CFR part 160 and 164), unless specifically protected by 42 CFT Part 2 governing confidentiality of alcohol and drug abuse records (see Note of Receiving Agency below).

I understand that I may revoke this authorization at any time by notifying the Privacy Officer of Adams Wells Special Services of my desire to revoke this authorization. I understand that if I revoke this authorization, it will not have an effect on information used or disclosed by Adams Wells Special Services prior to my action to revoke.

I understand this authorization will expire on (not to exceed 180 days): _____20____

_____ ____/____/____ _____ ____/____/____

Parent /Guardian Signature Date Witness Signature Date

_____ ____/____/____ _____

Person Representative's Signature Date Description of Representative's Authority

_____ _____

Printed Name of Signature Above Printed Name of Signature Above

Note of Receiving Agency: this information has been disclosed to you from records protected by Federal Confidentiality rules governing confidentiality of alcohol and drug abuse records, 42 CFR part 2, and applicable state statutes. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose.

Authorization For Release of Protected Health Information