STATE OF LOUISIANA

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

PART 1: CONTACT INFORMATION

Student's/Child's Legal Name	Date of Birth	Social Security #

Parent/Legal Guardian _____ Telephone # _____

Mailing Address _____

PART 2: RECORD REQUEST

Complete box A OR box B below. Both boxes may not be completed on the same form.

A. Specify the records to be released for the treatment date(s) listed below in Part 3:

q COMPLETE RECORD(S)

q Discharge Summary

☒ History & Physical

q Operative Report

q Consultation

☒ Progress Notes and School Order(s)

q Cardiopulmonary
(Indicate EKG, Stress Test, Sleep Study)

q Emergency Room

q Lab

q Pathology

q Radiology Results

q Other _____

_____

B. If initialed below, I specifically authorize release of the following:

Psychotherapy notes and records indicating psychological or psychiatric impairment(s)

Initials of parent/legal guardian

PART 3: AUTHORIZATION

This does not authorize the release of the following: drug and alcohol use counseling and treatment and HIV/AIDS and sexually transmitted disease testing and treatment.

I authorize:

Name: East Baton Rouge Parish School System (School System)