



## PERMISSION TO DISCLOSE RECORDS (HIPAA-COMPLIANT)

### Check appropriate box

- I, \_\_\_\_\_, an adult student (age 18 or older) (DOB \_\_\_\_\_),
- I, \_\_\_\_\_, parent/ legal guardian of \_\_\_\_\_, a minor student (DOB \_\_\_\_\_), hereby authorize: \_\_\_\_\_, hereafter referred to as "provider(s)," to disclose all records and information in their possession regarding the student to The RSEC Academy. The RSEC Academy's mailing address is P.O. Box 370 Amherst, NH, 03031.

This authorization allows the above provider(s) to copy and send records to The RSEC Academy and allows representatives of The RSEC Academy to inspect the records. This authorization also allows the above provider(s) to orally disclose information to The RSEC Academy, including but not limited to information contained in records.

This authorization encompasses all records pertaining to the student, including but not limited to correspondence, notes, reports, questionnaires, application forms, contracts, billing records, payment records, insurance records, work samples, discipline records, report cards, teacher grade books (with other students' names redacted), test protocols (questions and answers), test score calculations, any other test records, medical records, health records, counseling records, mental health records, computer data, and "third party records" created by any other individuals or organizations. The term "records" includes information recorded, maintained or preserved in any medium, including but not limited to printed, handwritten, magnetic, or electronic.

- I specifically authorize the release of HIV/AIDS results and/or treatment, where applicable.
- I specifically authorize the release of psychiatric records, where applicable.
- I specifically authorize the release of alcohol and substance abuse treatment records, where applicable.

Any costs for photocopying these records for The RSEC Academy, or for mailing these records to The RSEC Academy, shall be at The RSEC Academy's expense.

### Pursuant to HIPAA, the following are specified as part of this authorization:

- a. The purpose of disclosure is to help The RSEC Academy identify the student's needs and provide appropriate educational services.
- b. This authorization expires one year after the date it is signed.
- c. The person signing this form understands that he or she may revoke this authorization at any time by providing written notification to The RSEC Academy or to the provider(s) named above, except to the extent that this authorization has already been relied on.
- d. The person signing this form has been informed that the provider(s) named above may not condition treatment, payment, enrollment, or eligibility for benefits on whether that person signs this authorization.
- e. The person signing this form has been informed of the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to be no longer protected by HIPAA. However, the federal Family Educational Rights and Privacy Act (FERPA) generally prohibits The RSEC Academy and its employees and agents from disclosing student records (or information from those records) without prior written parental consent.

Date: \_\_\_\_\_ By: \_\_\_\_\_