Authorization For Release Of Mental Health/Education Record

STUDENT NAME _____ Date of Birth _____

Address (Mailing) _____ Phone_____

_____

I authorize Weber School District to use or disclose information from my mental health/education record, which may include information regarding my mental health, assessments, treatment, and/or substance abuse issues to:

Name: _____ Phone: _____

Address: _____ Fax: _____

Dates of Treatment: _____

Information to be released: _____

Purpose of Disclosure: _____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Weber School District, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for my mental health, except where disclosure of the information is necessary for the treatment.
4. My health care at Weber School District will not be affected if I do not sign this form.
5. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization:

_____ _____ OR _____ _____

Signature of Student Date Signature of Parent/Guardian Date

_____

Relationship to Student

Revised 08/30/2019