SPECIAL NEEDS SCHOOLS OF GWINNETT

AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

I authorize Special Needs Schools of Gwinnett, Inc. (SNS) to use or release the health information described below.
_____ Copies of all educational and therapeutic records for the period __/__/__.
_____ Copies of the information described below for the period __/__/__.
_____ Other (Please specify) _____.

The following information should ***not*** be released, even if occurring during dates above.
_____

Name of person and/or organization to which information should be sent _____
_____.

Address of location to which information should be sent
_____
_____
Please send information on or about __/__/__.
Purpose of disclosure: _____
_____I would like to review the information before it is sent.
I have been provided a copy of SNS's Notice of Privacy Practices and any changes that may be associated with this authorization. I have discussed any concerns that I may have about the use, release, disclosure, of my child's health information with SNS's Privacy Officer or other appropriate office personnel.
I understand that SNS assumes no responsibility for the use or misuse by others of my child's health information disclosed under this authorization. I release SNS from all legal liability that may arise from this authorization.

_____ _____
Student **Parent/Guardian**

_____
Date

The parent may revoke this authorization by notifying in writing SNS's Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal law also states that there is the potential for the protected health information released under this authorization to be subject to redisclosure by the recipient.