

RELEASE OF INFORMATION / ROI (SAMPLE)

USD 000 Release of Information

Student's Legal Name: _____	Date of Birth: _____
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I hereby authorize USD _____, its employees, agents, and assigns (collectively the "District") to use and/or disclose the protected health information identified below, for the purpose of educational evaluation, program planning, and health assessment/planning for this student, to ensure safe healthcare services in the school setting.

I authorize the following information to be disclosed (check all that apply):

- Diagnosis(es)
- Risk information
- Current medication(s)
- Treatment plan
- Safety plan
- Prognosis
- Other (please specify): _____

I authorize the following entities to disclose the information identified to the District.

Name of Authorized Entity

Phone / Fax / Email

Name of Authorized Entity

Phone / Fax / Email

Name of Authorized Entity

Phone / Fax / Email

Name of Authorized Entity

Phone / Fax / Email

In signing this release of information, I understand and acknowledge the following:

- This authorization is voluntary, and I may refuse to sign it.
- I may revoke this authorization at any time by notifying the District in writing of my intent to do so, except to the extent that action has been taken in reliance on this authorization. Any notice of termination must be sent to: _____
- Health records, once received by the District, will become education records protected by the Family Educational Rights and Privacy Act.
- The authorization will expire one year from the date listed by the student / legal representative signature below.

I, the undersigned, do hereby swear that I am the above-mentioned student or a legal representative of the above-mentioned student. I have read and understand the above information.

Signature of Student / Legal Representative

Name of Authorized Entity

Printed Name of Student / Legal Representative

Name of Authorized Entity



Kansas leads the world in the success of each student.