COBB COUNTY SCHOOL DISTRICT
A community with a passion for learning!
SPECIAL STUDENT SERVICES
514 Glover Street
Marietta, Georgia 30060

Form KM-1

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Student/Patient Full Name (Please Print): _____ Date of Birth: ___/___/___

Parent/Guardian Name (Please Print): _____ School: _____

I authorize the person or agency listed below to release protected health information, educational information, and/or otherwise confidential information.

PERSON/AGENCY RELEASING RECORDS (Please Print):

Name/Organization: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

THESE RECORDS MAY BE FORWARDED TO:

Name/Organization: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

☐ **Release to be reciprocal between persons/agencies listed above:**

- I understand that signing this authorization is voluntary and may be revoked at any time by providing a written notice to Cobb County School District. The withdrawal of this authorization does not affect any health information disclosed prior to this written notice.
- I understand that this information may be redisclosed by the Cobb County School District by means of record transfer, summative reports, etc., and at that point, the information may no longer be protected under the terms of this agreement.
- I place no limitation on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders.
- This authorization expires ___/___/___ (insert applicable date or event or insert "no expiration designated") or in 12 months, whichever is shorter.

The following information is to be released (Check All That Apply):

□ Psychological Reports	□ Medical Records	□ IEPs & Educational Plans	□ On-going Communication
□ Evaluations	□ Discipline Records	□ School Re-entry Plan	□ Consultation Regarding Student
□ Treatment Summaries	□ Social History	□ Observations/Work Samples	□ Other (specify): _____
□ Psychiatric Reports	□ Eligibility Reports	□ Anecdotal Records	

The purpose for which this release is being requested is (Check All That Apply):

☐ Educational Planning and Continuity of Care ☐ Medical Problems Related to Learning

☐ Proof of Disability ☐ Ongoing communication/consultation ☐ Other (specify): _____

Parent/Guardian Signature: _____ Date: _____