Since 1961

ST. ELIZABETH SCHOOL

Helping Students with Special Needs Go the Distance

Request for Protected Health and/or Educational Information

Date: _____/_____/_____

Student Name: _____ Birth Date: _____/_____/_____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

*By my signature below, I **authorize St. Elizabeth School to obtain** the following protected health and/or educational information ("PHI") as checked below:*

- ☒ All Records
- ☐ Psychiatric Reports
- ☐ Assistive Technology Assessments & Reports
- ☐ Audiology Assessments & Reports
- ☐ Behavior Intervention Data
- ☐ Educational Assessments
- ☐ Medical Records (Including Immunizations)
- ☐ Neuropsychological Reports
- ☐ Official Transcripts
- ☐ OT Assessments & Reports
- ☐ Psychological Assessments & Reports
- ☐ Psychosocial Summaries
- ☐ PT Assessments & Reports
- ☐ Speech & Language Assessments & Reports
- ☐ State Testing Scores
- ☐ Other: _____

Provider of PHI: _____
Address: _____
City: _____ State: _____ Zip: _____

Send to: Records Secretary ◆ St. Elizabeth School ◆ 801 Argonne Drive ◆ Baltimore, MD 21218

I understand that I may revoke this authorization in writing at any time except to the extent that St. Elizabeth School or its employees or agents have acted upon this authorization. My written revocation must be submitted to the provider of the Protected Health Information named above.

I understand that if the organization authorized to receive information is not a health plan or health care provider and if such information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations but may be protected under Maryland Law.

I understand that upon request I may receive a copy of this form after I sign it and that I may inspect and request a copy of the information I am authorizing for use/disclosure.

Signature of Student/Student's Representative: _____
Printed Name: _____
Relationship to Student: _____
Date: _____/_____/_____

Since 1961

ST. ELIZABETH SCHOOL

Helping Students with Special Needs Go the Distance

Release of Protected Health and/or Educational Information

Date: _____/_____/_____

Student Name: _____ Birth Date: _____/_____/_____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

*By my signature below, I **authorize St. Elizabeth School to release** the following protected health and/or educational information ("PHI") as checked below:*

- ☒ All Records
- ☐ Psychiatric Reports
- ☐ Assistive Technology Assessments & Reports
- ☐ Audiology Assessments & Reports
- ☐ Behavior Intervention Data
- ☐ Educational Assessments
- ☐ Medical Records (Including Immunizations)
- ☐ Neuropsychological Reports
- ☐ Official Transcripts
- ☐ OT Assessments & Reports
- ☐ Psychological Assessments & Reports
- ☐ Psychosocial Summaries
- ☐ PT Assessments & Reports
- ☐ Speech & Language Assessments & Reports
- ☐ State Testing Scores
- ☐ Other: _____

Provider of PHI: Records Secretary ◆ St. Elizabeth School ◆ 801 Argonne Drive ◆ Baltimore, MD 21218

Send to: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that I may revoke this authorization in writing at any time except to the extent that St. Elizabeth School or its employees or agents have acted upon this authorization. My written revocation must be submitted to:

Records Secretary ◆ St. Elizabeth School ◆ 801 Argonne Drive ◆ Baltimore, MD 21218

I understand that if the organization authorized to receive information is not a health plan or health care provider and if such information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations but may be protected under Maryland Law.

I understand that upon request I may receive a copy of this form after I sign it and that I may inspect and request a copy of the information I am authorizing for use/disclosure.

Signature of Student/Student's Representative: _____

Print Name: _____

Relationship to Student: _____

Date: _____/_____/_____