

Mid Columbia Transition Team Authorization For Release & Exchange of Information

We can serve you better if we are able to work collaboratively with agencies and health care providers who are, or may soon be involved with you or your child and family. By signing this form, you are giving permission for these individuals, providers or organizations to share information among each other.

Student Name: _____ Date of Birth: _____
 Other names used by student: _____ Social Security #: _____

I, _____ Student *or* Parent/Guardian authorize the release and exchange of information, both written and verbal, between and among the identified Mid-Columbia Transition Team members, who will be planning transition services for me, my child, _____ (Students Name)

The purpose of the exchange of information is to better serve you/your child through:

- Identifying skills and goals said student
- Identifying services in place to meet those goals
- Identifying gaps in services
- Identifying and planning for health issues that affect said student
- Allowing team planning and coordination of services among agencies/providers
- Determining eligibility for adult services that may be available for you/your child
- Planning for a smooth transition process into the adult world

I agree that the listed agencies may: Release information to: Obtain information from: Exchange information

Initial	Name	Initial	Name
	County School District (specify)		Parent Representative
	Office of Vocational Rehab		The ARC
	Eastern Oregon Support Services Brokerage		Transition Learning Center
	Columbia Gorge Center		SOC/ Columbia River Wraparound
	Center For Living/DD Service Coordinator		Public health nurse/School Nurse
	MCCOG		

To help the team determine the best resources for you/your child, please check the appropriate box re: medical coverage.
 OHP/Medical Card Private Insurance No Medical Card or Insurance

By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:

<input type="checkbox"/> Physician's Eligibility Statement	<input type="checkbox"/> Educational Information	<input type="checkbox"/> Psychological evaluations
<input type="checkbox"/> Health Assessment Statement	<input type="checkbox"/> IFSP/IEP document	<input type="checkbox"/> Social work reports
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Clinic records	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Entire medical record	<input type="checkbox"/> Communicable disease(s)	<input type="checkbox"/> _____
<input type="checkbox"/> Prenatal information	<input type="checkbox"/> Progress notes	<input type="checkbox"/> _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my *initials* in the applicable space next to the type of information. Specific information requested must be listed.

_____ HIV/AIDS information
 _____ Mental Health information
 _____ Genetic testing information
 _____ Drug/Alcohol diagnosis, treatment, or referral information

I understand that (1) this authorization is voluntary; (2) I may give written cancellation of this release at any time, but this cancellation will not affect any information that was released prior to the cancellation; (3) I have a right to request a copy of this form after I sign it as well as inspect or copy any information to be used or disclosed under this authorization; (4) the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

This authorization expires on _____ (not to exceed one year from the date of signing).

I have read this authorization, I understand it, and I consent to the use/disclosure of the above information.

 (Signature of Student *or* Parent/guardian)

 (Witness)

 (Date)