DISCLAIMER: This form is a general reference intended only to illustrate sufficient compliance with relevant law and policy. It is NOT a substitute for understanding federal and state guidelines and/or the appropriate state and local policies nor is it a comprehensive description of all applicable legal and contractual obligations.

[LEA]

CONSENT TO RELEASE BEHAVIORAL HEALTH INFORMATION
(Including Paper, Oral, and Electronic Information)

Your written consent allowing communication between your outside behavioral health provider and Orleans Parish School Board is required by law (La. R.S. 17:173(h)). Please complete all blanks below.

Student Name	Date of Birth
Street Address	City/State/Zip
School	Grade

I hereby authorize:

Name: _____

Street Address:_____

City/State/ZIP:_____

Phone Number: _____

To Release Protected Medical And Behavioral Health Information To:

NAME: _____
[LEA]
[Street Address]
[City, State, Zip]
[Phone Number]

I authorize and consent to the release of protected medical and behavioral health information related in any way to the behavioral health provider evaluation and services rendered to my child while at school during the school day, including medical history, medications, examinations and reports, hospital records, treatment records, progress reports, and any and all other information directly or indirectly pertaining to my child's identified behavioral health needs.

This authorization and consent shall expire one year from the date on which it is signed.

_____
Printed Name of Parent/Guardian

_____ _____
Parent/Guardian Signature Date