DODDRIDGE COUNTY SCHOOLS
AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

To: _____

_____

_____

I hereby authorize _____ records of _____
(Specific Type of Record) (Student's Name)

_____ to be released to: _____
(Date of Birth) (Name of Person/Agency)

_____

_____ _____
(Phone) (Address)

This authorization is for the purpose of providing educational services. This authorization also permits you to confer with the named person/agency for this same purpose. This authorization is valid and does not expire until _____. I understand that the records provided pursuant to this authorization will become part of my son's/daughter's educational records. These records and any protected health information used or disclosed based on this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act's privacy rules. I understand that in regards to medical records that my son"s/daughter's treatment, payment, enrollment in any health plan, or eligibility for benefits may not be and are not conditioned upon my agreeing to sign this authorization. I also understand than I have a right to revoke this authorization by sending a letter to Doddridge County Schools, 104 Sistersville Pike, West Union, WV requesting that this authorization no longer be used.

_____
(Signature of Parent/Guardian/Eligible Student)

Doddridge County Schools
103 Sistersville Pike
West Union, WV 26456
(304) 873-2300 Fax 873-2210

_____
(Name and Legal Title/Authority)

_____
(Date)