BROOK LANE
Hope • Healing • Recovery

LAUREL HALL SCHOOL
HAGERSTOWN, MD

Consent for Release of Information

On behalf of, _____ Date of Birth _____
Child's full name

I, _____ authorize **Brook Lane Health Services / Laurel Hall School**
Parent or Legal Guardian full name

to exchange the below information with: _____
Name or Title of person or organization

_____
Address and/or phone number of organization

Please select information request below (Please answer completely and specify)

- ☐ Verbal Exchange of Information
- ☐ Written Exchange of Information
- ☐ Out of Class Visits **Duration:** _____
- ☐ In Class Visits **Duration:** _____
- ☐ Transportation
- ☐ Other: _____
- ☐ Other: _____

- ☐ Educational Records *(please specify below)*

_____
_____
_____
_____
_____
_____

If in class or out of class visits are required, further communication with education team will be necessary to determine a schedule to minimize disruption to instruction.

I understand that my authorization shall remain effective for a period of one year from the date of my signature and that all information released will be handled confidentially, in compliance with the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 92-282), and the Maryland Mental Health Code HG §8-601.

I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written dated communication to the Director of Health Information of Brook Lane Health Services.

It is agreed that the recipient of this information will refrain from and will protect against disclosure of any information received which is not authorized by further consent of the patient of his/her parent, guardian or authorized representative unless provided for under law or regulation.

I understand that I may not be required to sign this authorization as a condition of my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____
Student Signature *Parent or Guardian Signature*

_____ _____
Witness *Date*