Special Education Division
900 Watervliet-Shaker Road
Albany, NY 12205
(518)-464-6300

Authorization for Release of Information

Student Name: _____ DOB: _____

I authorize Capital Region BOCES to: ☐ obtain from ☐ release to

Person/Agency: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

The following information:

Obtain	*Release*	
☐	☐	Diagnosis only
☐	☐	Admission/Psychiatric Assessment
☐	☐	Discharge Summary (verbal or written)
☐	☐	Psychological Testing
☐	☐	Medical History/other medical information

Obtain	*Release*	
☐	☐	Applications
☐	☐	Progress Notes
☐	☐	Educational Materials/Verbal
☐	☐	Reports Immunization Records
☐	☐	Educational Records
☐	☐	Other (please specify):

The information will be used for the following purpose(s):

☐ Evaluation and Continuing Treatment ☐ Educational Placement/Concerns/Billing
☐ Coordinating Care ☐ Other (please specify):

I understand that I have the right to revoke this authorization at any time by submitting a revocation in writing to Capital Region BOCES. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to protest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information.

If the disclosure is for educational purposes, I understand the recipient may be my child's home school district and any school within the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my child's participation in his/her educational program. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information caries with it the potential for unauthorized re-disclosure by the recipient and the information may not be protected by the federal privacy rules or by New York State law.

_____ _____
Signature of parent/legal guardian Date

_____ _____
If signed by legal guardian, relationship to student Signature of witness