RELEASE & EXCHANGE OF INFORMATION
School or Behavioral Situations

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone: _____

I HEREBY REQUEST AND AUTHORIZE YOU TO FURNISH ALL THE REQUESTED INFORMATION FROM/TO:

INFORMATION FROM: Catalyst Medical Group | Valley Medical Center
2315 8th Street, Lewiston, Idaho 83501 · Fax: 1.833.941.3874

INFORMATION TO: Special Services Programs & Personnel
(Including, but not limited to: Teachers, Principals, Psychologists, Counselors, Therapists)

School / Institution: _____

Mailing Address: _____

City, State Zip: _____

I REQUEST THE FOLLOWING INFORMATION TO BE RELEASED:

- ❑ Mutual Exchange of Information; Behavioral Health; Behaviors and Testing; Progress Notes

THE TIME PERIOD THIS RELEASE IS VALID FOR IS:

- ❑ One Calendar School Year (From July 1, _____ to June 30, _____)

Please select the school district you / your child attends:

- ❑ Lewiston School District
- ❑ Clarkston School District
- ❑ Asotin/Anatone School District
- ❑ _____ School District

PLEASE READ CAREFULLY:
By signing this form, I certify that I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS Virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that the Catalyst Medical Group cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information be furnished. This request is a free and voluntary act by me. I hereby release Catalyst Medical Group and its staff and providers from all legal responsibility that may arise from the release of medical information hereby authorized. **I understand this release can be revoked at any time by providing a written notice requesting such action.**

CONSENT OF MINOR AGED 14-15
If the patient is 14 years of age or older, only the patient may authorize the disclosure of information relating to treatment for contraception, pregnancy termination, sterilization, sexually transmitted disease, and mental health conditions. I understand that the signature(s) below authorize the release of this information. *(Per Federal HHS Standards and also Idaho Code, including § 39-4503, §39-4504 and §18-609A.)*

CONSENT OF MINOR AGED 16-17
If the patient is 16 years of age or older, only the patient may authorize the disclosure of information relating to treatment for contraception, pregnancy termination, sterilization, sexually transmitted disease, mental health conditions, **and alcoholism, or drug abuse**. I understand that the signature(s) below authorize the release of this information. *(Per Federal HHS Standards and also Idaho Code, including § 39-4503, §39-4504 and §18-609A.)*

⌦ **Parent/Guardian Signature:** _____ Date: _____
(Required if patient is 13 years of age or younger and in many cases for patients ages 14-17)*

⌦ **Patient Signature:** _____ Date: _____
(Required in most cases if patient is 14-17 years of age, as listed above)*

CATALYST MEDICAL GROUP · VALLEY MEDICAL CENTER
2315 Eighth Street · Lewiston, Idaho 83501
Tel: 208.746.1383 · Fax: 833.941.3874 · www.catalystmedicalgroup.com