8710.4 AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Threat Assessment)

MEDICAL PROVIDER: Dr. Lisa A Pattison
ADDRESS: 3280 Woodridge Blvd. Ste 200
Grand Island, NE 68801

STUDENT NAME: DOB:

I, _____, on behalf of my child, _____,
[parent name] [student name]

authorize Dr. Lisa a Pattison and Cornerstone Counseling PC to disclose my son's identifiable health information to:

Grand Island Public Schools
Attn: Dr. Robin Dexter, Associate Superintendent
Kneale Administration Building
123 South Webb Road
P.O. Box 4904
Grand Island, NE 68802

The following individually identifiable health information shall be disclosed:
Any information concerning psychiatric/psychological condition, psychiatric/mental health treatment, psychiatric/psychological testing and/or mental health evaluation.

Dates of treatment to be released: All.

Reason or purpose for the use and/or disclosure of the information:
Grand Island Public Schools is requesting a mental health evaluation of:

Student Name: _____

Expiration:
This authorization will expire automatically after 180 days from date of signature or upon satisfaction of the need for disclosure as specified. Furthermore, it shall be construed that this authorization allows only the following individuals to be in receipt of said evaluation: Superintendent, Associate Superintendent, and members of the Reentry Team-which usually includes the Principal, parent, student and counselor. No

other persons will have access to the evaluation. The school will destroy the mental health evaluation after 30 days

This Authorization is binding:
The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the medical provider's Notice of Privacy Practices.

_____ _____

SIGNATURE OF PARENT DATE

_____

[parent name]

_____

[student name]

Form Created Sept 2018