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DEPARTMENT OF EDUCATION

STUDENT SUPPORT SERVICES DIVISION

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Christopher Anderson
Administrator

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

FORM TO BE COMPLETED BY: Parent or Legal Guardian

This form is in compliance with the Federal Confidentiality Law
Government Substance Abuse Patient Record (42 CFR Part 2) and Health Insurance Portability Accountability Act (HIPAA) 45 CFR

1. Student Information

A. Student Name and Mailing Address:

B. Student ID: _____

C. Date of Birth: _____

2. Name and Address of:

A. Requestor, if not the same as student: _____

B. Institution holding and releasing information: _____

C. Person or Institution to receive information: _____

3. Type of Information (Initial Below)

A. Substance Use Information _____

D. Psychological Information _____

B. HIV/AIDS Related Information _____

E. Medical Information _____

C. Healing Heart Information _____

4. Initial specific information to be disclosed & specify time period from _____ to _____

_____ Summaries _____ Physical Examinations _____ Psychological Evaluations

_____ Demographics _____ Progress Notes _____ Other

5. Initial purpose for the release

_____ Medical Follow-Up _____ Legal _____ Personal

_____ Other, explain _____

This consent has been made freely, voluntarily, and without coercion. Those who receive this information cannot disclose it to others unless permitted by Federal or State Law. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure had already taken action in reliance on it. This release is not valid after 12 months of the date of signature unless otherwise specified.

Date Signed

Parent/Legal Guardian's Signature

Date Witnessed

Employee's Signature & Title

Print Name & Title of the Employee Providing Information

Signature of Employee Providing Information

Date

If date of revocation is prior to 12 months, complete this section.

Date Revoked

Parent or Legal Guardian's Signature

Date Witnessed

Employee's Signature & Title

