Fulton County Schools
Where Students Come First

MENTAL HEALTH PROVIDER PARENTAL AUTHORIZATION AND WAIVER

Student/Patient Name (Please Print):_____ Date of Birth _____

Parent/Guardian Name (Please Print):_____School:_____

I am the parent/guardian of the above-referenced student. My parental/guardianship rights have not been terminated or relinquished, and there is no court order or agreement that states that I may not have access to educational information or records about my son/daughter. I authorize Fulton County School District to release any and all requested educational records and information to the following:

Provider Name/Organization:_____

Address:_____ Phone:_____

City:_____ State: _____ Zip: _____ Fax:_____

The party receiving the above specified records acknowledges that information from these records cannot be disclosed to any other party without my prior consent.
The purpose of this release request is (check all that apply):

[ ] Educational Planning and Continuity of Care
[ ] Medical Problems related to Learning
[ ] Ongoing Communication/Consultation
[ ] Social/Emotional/Behavioral Concerns
[ ] Other (specify): _____

As the parent/guardian, I consent to the above provider having access to my child and my child's information at school. I understand that this provider is requesting my permission to perform the following services while at school:

_____

_____

I understand and give permission for the provider to be alone with my child to provide these services. I understand that District staff members are not responsible for monitoring or determining the type and extent of services provided to the student. I understand that my child may miss instruction and special services during the times this provider is visiting, **and these instructional activities and services will not be made up by the District**. I understand it is my responsibility to ensure the provider comes for appointments with the student on the dates and times allowed by the District. I understand the District may terminate or restrict the ability of a provider to be on campus at any time.

The parent/guardian, for himself/herself and on behalf of the student, hereby waives all claims against any current, former, or future volunteer, employee, or agent of Fulton County School district or Fulton County Board of Education, as well as Fulton County School District and Fulton County Board of Education, and releases them from any and all claims, demands, actions, liabilities, or damages (including but not limited to attorney's fees), whether known or not unknown, arising out of relating in any way whatsoever to the provision of services by any health of educational provider pursuant to this Authorization and Waiver and further acknowledges that under no circumstance shall the District assume responsibility of any sort for services provided pursuant to this Authorization and Waiver. This waiver and release includes, but is not limited to, claims arising under any and all federal, state, and local constitutions, statutes, ordinances, and regulations, including but not limited to, the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____