SCHOOL DISTRICT OF CAMBRIDGE

403 Blue Jay Way.

CAMBRIDGE, WI 53532

HIPAA-Compliant Authorization for Exchange of Health & Education Information

Patient/Student Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

I hereby authorize _____]

[*insert name & title of school official*]

to exchange health and education information/records for the purpose listed below.

Name, Address & Telephone of School/School District:	**Name, Address, & Telephone of Health Care Provider**
_____	_____
_____	_____
_____	_____
Telephone: _____	**Telephone** _____

Description:

The health information to be disclosed consists of:

- ❑ Comprehensive overview of patient health care records: _____
- ❑ Records pertaining to (dates or conditions): _____
- ❑ Other (describe): _____

The education information to be disclosed consists of: (Dates, if appropriate)

- ❑ All Pupil Records (Progress or Behavioral) _____
- ❑ Psychological or Social Work Records _____
- ❑ Records of School Therapists (OT, PT, Speech/Lang) _____
- ❑ Individual Education Programs _____
- ❑ Other (describe) _____

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

__ 1. Educational evaluation and program planning

__ 2. Health assessment and planning for health care services and treatment in school

__ 3. Medial evaluation and treatment.

__ 4. Other (describe) _____

Authorization

This authorization is valid for **one calendar year**. It will expire on _____[*insert date*]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25(2m)(a)(b) and 146.82-146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____ _____

Signature of Parent or Legal Guardian Relationship to Student Date

_____ _____

Student Signature * Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Wisconsin, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for HIV/AIDS, and family planning services.

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

12/03 Draft