Sycamore Community Unit School District #427
245 W. Exchange Street
Sycamore, IL 60178
815-899-8117
FAX: 815-899-8127

Authorization for Use and Disclosure of Protected Health Information and Education Records

Patient/Student Name:_____ **Date of Birth:** _____

I hereby authorize: _____
_____
_____

To disclose protected health information and/or educational records to:

_____
_____
_____

___Check here if authorization is given for the parties listed above to mutually exchange the information below.

Description:
The medical information to be disclosed consists of (check all that apply):
___Medical history and/or physical ___Immunization record ___Lead screening
___Nursing assessment ___School physical forms ___Medication records
___Treatment plans ___TB or other lab results ___HIV information
___Information related to the following injury or condition: _____

The mental health information to be disclosed consists of (check all that apply):
___Treatment plans ___Clinical assessments ___Clinical notes
___Psychiatric evaluations ___Discharge summaries ___Treatment notes
___Psychological/Neuropsychological Evaluations ___Social assessment/history
___Records covering the period of time from _____ to _____

The education information to be disclosed consists of (check all those that apply):
___Grades/report cards/transcripts ___IEPs/504 plans/eligibility documents
___Psychological evaluations ___Health histories
___Social assessments/histories ___Speech and language evaluations/reports
___Assistive technology information ___Behavioral/discipline information
___Neuropsychological evaluations
___Educational testing (local and state assessments)
___Occupational/physical therapy evaluations/reports
___ Records covering the period of time from _____ to _____

The substance abuse information to be disclosed consists of (check all those that apply):
___Substance abuse history ___Treatment, attendance placement and progress
___Discharge/continuing care plan

This authorization is valid for one calendar year and will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their contents.

Parent Signature Date

Student Signature (If student is over 12 years of age and the authorization is for the release of mental health records) Date

Witness Signature Date