AUTHORIZATION TO EXCHANGE HEALTH & EDUCATION INFORMATION

Dear _____: Date _____

Parental signature is required in order for us to obtain and/or release information regarding your child _____. Therefore, we are requesting that you **please sign and return one copy of this form in the self-addressed, stamped envelope that is included.** You may keep the other copy for your records.

Description:
The health information to be disclosed consists of:

- ☐ Medical and/or related health records.
- ☐ Psychological evaluations or social work reports.
- ☐ Appropriate agency reports.
- ☐ Other (specify): _____

The education information to be disclosed consists of:

- ☐ Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results).
- ☐ Evaluation Team and related reports.
- ☐ Psychological evaluations or social work reports.
- ☐ Individualized Education Plan (IEP).
- ☐ Other (specify): _____

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. Medical evaluation and treatment.
4. Other (specify): _____

If you have any questions, please contact me at _____.

_____
(Name and Title of School District Representative)

AUTHORIZATION TO EXCHANGE HEALTH & EDUCATION INFORMATION

I, hearby authorize Central High School, 24617 - 75th Street P.O. Box 38, Salem, WI 53168, (262) 843-2321; fax: (262) 843-4069
[Health care provider name, title, address, & phone]

and _____
[School official name, title, address & phone]

to exchange health and education information/records for the purposes listed above.

Child's Name: _____ **Date of Birth:** _____

This authorization is valid for one calendar year. It will expire on _____. 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 educational 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 **Date**

_____ _____
Signature of Student* **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.