HIPAA & FERPA Compliant Authorization for Exchange of Health & Education Records & Information

Patient/Student Name: ____

Date of Birth: ____

I hereby authorize ____ (**healthcare provider name & title**)

Address: ____

Phone & Email: ____

AND the Shawnee Mission School District (c/o name/title) ____________________________________ located at 8200 W. 71st Street, Overland Park, KS. 66204 to disclose and release health and education records and information for the purpose(s) listed below.

Purpose (check all applicable boxes):

- ❏ Physical Exam (most recent)
- ❏ Statement of the current diagnosis and treatment including orders of treatments needed at school
- ❏ Immunization Records
- ❏ Reciprocal sharing of information pertinent to diagnosis, academic needs, or progress
- ❏ Other health records (please specify) ____

The education information to be disclosed consists of (check all applicable boxes):

- ❏ School Cumulative Records (including grades, attendance & discipline)
- ❏ Current Report Card
- ❏ Special Education Records
- ❏ Reciprocal sharing of information relevant to educational needs
- ❏ Other education records (please specify) ____

This information will be used for the following purposes:

1. Health assessment and planning to ensure safe health care services and treatments at school
2. Education evaluation and program planning
3. Other (please specify) ____

Authorization

This authorization is valid for the school year, 20_____-20_____ and/or will expire on ____________ (insert date). I understand that I may revoke this authorization at any time by submitting written notice withdrawing consent. I understand that health records, once received by the school district, will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

PARENT/GUARDIAN: ____

Signature Date

STUDENT (if 18 or older): ____

Signature Date