WAUNAKEE COMMUNITY SCHOOL DISTRICT
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Pupil Name: _____ Date of Birth: _____

INSTRUCTIONS: **STEP 1:** Complete the *Authorization Statements* section below by placing a checkmark by **ONE OR BOTH** of the statements. In order to allow the exchange of information between the Waunakee Community School District and the identified individual/entity, please check both of the Authorization Statements. **STEP 2:** Complete the *Information To Be Disclosed* section by placing checkmarks by the information that may be disclosed. **STEP 3:** Complete the *Purpose of Disclosure* section by placing checkmarks by the appropriate purpose of disclosure. **STEP 4:** Review the *Acknowledgements & Signature* section and sign the authorization.

AUTHORIZATION STATEMENTS

☐ DISCLOSURE BY SCHOOL DISTRICT. I authorize the Waunakee Community School District to disclose by any means (including written, oral or electronic means) the information indicated below regarding the pupil to:

Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone: _____

☐ DISCLOSURE TO SCHOOL DISTRICT. I authorize _____ (insert name of individual, organization, or agency) to disclose by any means (including written, oral or electronic means) the information indicated below to the Waunakee Community School District.

Name: _____
Address: _____
_____
Phone: _____

INFORMATION TO BE DISCLOSED

Education Information/Records

- ☐ Progress Records
- ☐ Behavioral Records
- ☐ Pupil Physical Health Records
- ☐ IEP/Evaluation Reports
- ☐ Special Education Records
- ☐ Psychological Records

Health Information/Records

- ☐ Patient Health Information (specify or indicate "all")
  _____
  _____
  _____
  _____
- ☐ Outside Provider Evaluation Report(s)
- ☐ Immunization Record(s)
- ☐ Mental Health Records
- ☐ HIV (AIDS) Records
- ☐ Developmental Disabilities

Other Information/Records:

Other (specify) _____
_____
_____
_____

PURPOSE OF DISCLOSURE

- ☐ Educational Programming and Service
- ☐ Medical Evaluation and Treatment
- ☐ Other _____
- ☐ Health Assessment and Planning
- ☐ Transition Planning

ACKNOWLEDGEMENTS AND SIGNATURES

Right to Inspect or Copy the Health Information to be used or disclosed---I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department or school.

Right to Receive Copy of this Authorization---I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to refuse to sign this Authorization---I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdraw this Authorization---I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department or school. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Re-release---If the person(s) and/or organizations authorized by this form to receive your health information are not health care providers or other people who are subject to federal health privacy laws, the health information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-lease your health information without your prior permission.

This permission is valid for one year. A copy of this form is as effective as the original. I certify that I am the parent, legal guardian, personal representative of the above named pupil, or that I am the pupil and of appropriate age, and have authority to sign this authorization.

Signature: _____ Print Name: _____

Relationship to Pupil: _____ Date: _____
(pupil, parent, guardian, or personal representative)

☐ Check here if you are requesting a copy of education records disclosed by the Waunakee Community School District (a fee for education record copies may be imposed).

Copies to: Requestee, Requestor, Parent /Guardian/Legal Custodian/Adult Student