Luxemburg-Casco School District

HIPAA-Compliant Parent/Guardian Authorization for Exchange of Health & Education Information

Patient/Student Name:_____Date of Birth:_____/_____/_____

I hereby authorize_____(_____)_____-_____
(health care provider name, title, & phone number)

_____
(address of health care provider)

And_____(__ __)_____-_____ext _____
(school official name, title, & phone number)

_____
(address of school district)

to exchange health/education information records which I have indicated below.

_____ Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results)

_____ Medical and/or related health records _____ Psychological evaluations or social work reports

_____ Appropriate agency reports _____ Others (Specify)

_____ Individualized education program (IEP) or 504 team evaluations and related reports

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: _____

Authorization

This authorization is valid for one year from the date signed. 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 or 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 the 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.

_____
Parent/Guardian Signature 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*, Health care provider, School official requesting/receiving the protected health information.