



# Authorization to Use and Exchange Protected Health and Education Information

Today's Date \_\_\_\_\_

Student's Full Legal Name (first, middle, last) \_\_\_\_\_

Child's Gender  Male  Female Child's Date of Birth (month/day/year) \_\_\_\_\_

Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### AUTHORIZES:

Name of person or organization: \_\_\_\_\_

Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

### To EXCHANGE protected health/education information with:

Wausau School District - School: \_\_\_\_\_

Contact person: \_\_\_\_\_

Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

### Protected Health Information to be Used and Exchanged (check all applicable categories):

- Medical history and notes
- Assessment summary
- Treatment plan
- By a specific doctor or for a specific diagnosis (specify name of doctor or diagnosis)
- Any and all medical records of the above named patient relating to the identity, diagnosis, prognosis or treatment of HIV/AIDS (including HIV/AIDS test results), or alcohol and other drug dependency, and of mental health and developmental disability ("Highly Confidential Information")
- Other, specify: \_\_\_\_\_
- Immunizations
- Surgical reports
- Hospital records
- Prescriptions
- Correspondence
- X-Ray, EKG, EEG, Lab reports

### Education Information to be Used and Exchanged (check all applicable categories):

- Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results)
- Individualized education program
- Individual Education Program (IEP)/Multidisciplinary team evaluations and related reports
- Psychological evals or social work reports
- Appropriate agency reports
- Other, specify: \_\_\_\_\_

Time Period for Which Records Are Requested:  From \_\_\_\_\_ to \_\_\_\_\_ OR  All Records

### Purpose and Use of Exchange:

- Continuing/coordinating health care services and treatment in school
- Individual Education Planning/Transitioning
- Other, specify: \_\_\_\_\_

### Expiration Date: This authorization will remain in effect

- From the date this authorization is signed until the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_
- Until I cancel this authorization in writing.
- Until the following event occurs, specify event: \_\_\_\_\_
- Other \_\_\_\_\_

In compliance with Wisconsin law, which requires special permission to exchange otherwise privileged information, I specifically authorize the use and exchange of my Highly Confidential Information selected above, if any. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of student's legal representative \_\_\_\_\_ Relationship to Student \_\_\_\_\_

**REDISCLASURE NOTICE:** I understand that if the person(s) and/or organizations(s) listed above are not health care providers, health plans or health care clearinghouses, the health/education information exchanged as a result of this authorization may no longer be protected by the Federal privacy standards and my health/education information may be redisclosed by such person(s) and/or organization(s) without obtaining my authorization.

#### **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION**

- **Right to receive copy of this authorization** - I understand that if I sign this authorization, I will be provided with a copy of this authorization.
- **Right to refuse to sign** - I understand that refusal to sign, will not interfere with my child's ability to obtain health care.
- **Right to withdraw this authorization** - I understand that if I want to cancel this authorization, I must do so in writing. To obtain a form to cancel this authorization, I may contact the Wausau School District. I understand that my cancellation will not be effective as to uses and/or exchanges of my information that the person(s) and/or organization(s) listed above have made prior to the receipt of my cancellation form.
- **Right to inspect a copy of the health/education information to be used or exchanged** - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health/education information I have authorized to be used or exchanged by this authorization form. I may arrange to inspect my health education information or obtain copies of my health/education information by contacting the Health Care Provider or school.
- **HIV test results** - I understand my HIV test results may be released without authorization to persons organizations that have access under Wisconsin law and a list of those persons/organizations is available.
- **Mental health treatment records** - I understand that I have the right to inspect and receive a copy of my mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.