D.C. Everest Area School District

Authorization to Use and Exchange Protected Health and Education Information

Student's Name: _____ Birthdate: _____

Street Address: _____ City: _____State: ____ Zip: _____

Authorizes Name of person or organization:	**To Exchange** Protected health/education information with:
_____	D.C. Everest Area School District School: _____
_____	Contact Person: _____
Street Address:_____	Street Address: _____
City, State, ZIP	City, State, ZIP

PROTECTED HEALTH INFORMATION TO BE USED AND EXCHANGED (check all applicable categories)

☐	Medical history and notes	☐	Immunizations	☐	Prescriptions
☐	Assessment summary	☐	Surgical reports	☐	Correspondence
☐	Treatment plan	☐	Hospital records		
☐	X-Ray, EKG, EEG, Lab reports				
☐	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				

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)
☐	Psychological evaluations or social work reports
☐	Individual Education Program (IEP)/Multidisciplinary team evaluations and related reports
☐	Appropriate agency reports
☐	Individualized education program
☐	Other (specify)

TIME PERIOD FOR WHICH RECORDS ARE REQUESTED (check applicable category)

☐ Records from (date) _____ to _____ ☐ All available Records

PURPOSE OF USE AND EXCHANGE (check applicable category)

☐ Continuing/coordinating health care services and treatment in school
☐ Individual Education Planning/Transitioning
☐ Other, specify _____

EXPIRATION DATE: This authorization will remain in effect (check applicable category)

☐ One year from the date this authorization is signed.
☐ 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

REDISCLOSURE 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 D.C. Everest Area 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 organizations(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.
- **Copies** – A copy of this authorization is as valid as the original.