Hillsboro SD 1J

Authorization to Use and/or Disclose Educational and Protected Health Information

1. I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child.

(Student/Child's Name) (Date of Birth) (Student ID#)

(Other Names Used by Student/Child) (School or Program Name)

Name and address of health care provider authorized to:
- ☐ Send/disclose protected health information
- ☐ Receive/use educational information

Name and address of school/EI/ECSE program authorized to:
- ☐ Send/disclose educational information
- ☐ Receive/use protected health information

2. I understand that this information will be used for the following purposes (check all that apply):
- ☐ Determining eligibility for Special Education, EI/ECSE, or other services
- ☐ Determining student/child's current levels of performance
- ☐ Developing an individualized health plan
- ☐ Developing an appropriate Individualized Education Program or Individualized Family Service Plan
- ☐ Other (specify):

3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:
- ☐ Physician's Eligibility Statement
- ☐ Health Assessment Statement
- ☐ History and physical exam
- ☐ Entire medical record
- ☐ Prenatal information
- ☐ Educational Information
- ☐ IFSP/IEP document
- ☐ Clinic records
- ☐ Communicable disease(s)
- ☐ Progress notes
- ☐ Psychological evaluations
- ☐ Social work reports
- ☐ Other:

4. By initialing the spaces below, I authorize the use/disclosure of the following information. Specific records requested must be listed below, e.g., assessment, treatment plan, discharge plan.

_____Drug/alcohol diagnosis, treatment or referral information requested:

_____HIV/AIDS related records requested:

_____Mental health related information requested:

_____Genetic testing information requested:

5. I understand that:

a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care.

b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

c. I may revoke this authorization at any time by notifying _____ in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

d. Federal privacy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

6. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.

(Signature of Parent, Legal Guardian, Student/Child) (Date)

(Relationship)

This authorization expires on _____(Month/Day/Year) (not to exceed one year from date of signature above).