WEST DES MOINES COMMUNITY SCHOOLS

Authorization for Exchange of Information

Student Name: _____ **Birthdate:** _____
Parent/Guardian: _____ **Phone (primary):** _____
Address: _____ **Phone (alternate):** _____
City, State, Zip: _____

Parent/Guardian/Eligible Student (over 18, own guardian):
Your signature on this Authorization for Exchange of Information will give the individuals, programs, organizations, and entities listed on the following page(s) of this Authorization permission to exchange the information indicated below.

The purpose for this exchange of information is:

_____
_____
_____

Your signature will give your permission for the following specific information to be exchanged:
☐ Medical Status ☐ Current Medications/Treatments ☐ Recommendations for School
☐ Other: _____

Information in the following areas may not be exchanged without your special permission. Your signature will give your special permission for the exchange of information in the areas indicated:
☐ Mental Health ☐ Substance abuse/chemical dependence ☐ Sexually transmitted disease ☐ HIV/AIDS

Before giving your permission for exchange of information, please carefully review the following:

This authorization is good until the following date, ____/____/____, or until one year after the date of signing, whichever occurs first. You may revoke this authorization, in writing, at any time, however, this does not affect information shared prior to your request for revocation. All members of the IEP team and, as appropriate, those identified as having legitimate educational interest may review the information received. The information may also be used in the future, including if the student moves, for the purpose of IEP decision making.

Health Insurance Portability and Accountability Act (HIPAA)/Family Educational Rights and Privacy Act (FERPA) Notice:

Any and all personally identifiable information regarding children receiving special education services funded under the Individuals with Disabilities Education Act (20 U.S.C. section 1400 et seq.) is protected from unauthorized disclosure under FERPA. Personally identifiable information protected by FERPA is specifically exempted from HIPAA privacy standards. FERPA prohibits disclosure of personally identifiable information without parent consent except in limited circumstances, requires notice to be provided to the child's family regarding their privacy rights, requires providers to keep records of access to a student's records, and contains complaint and appeal procedures which apply to disputes over records in possession of special education or its providers, among other provisions. All special education providers comply with these procedures.

If you have questions, please contact:
Contact Person: _____ District/Agency: _____
Address: _____ Phone: _____
City, State, Zip: _____ Email: _____

Original: Agency Copy: WDMCS Copy: Parent/Guardian

I understand my rights related to this exchange of information. As per the conditions described in this Authorization for Exchange of Information, I consent to the exchange of information with the individual(s), program(s), organization(s), and entity(ies) listed below.

_____ _____

Signature of Parent/Guardian/Eligible Student Date

1	**Name: _____ Agency/Relationship: _____** **Address: _____ Phone: _____** **City, State, Zip: _____ Fax: _____**
2	**Name: _____ Agency/Relationship: _____** **Address: _____ Phone: _____** **City, State, Zip: _____ Fax: _____**
3	**Name: _____ Agency/Relationship: _____** **Address: _____ Phone: _____** **City, State, Zip: _____ Fax: _____**
4	**Name: _____ Agency/Relationship: _____** **Address: _____ Phone: _____** **City, State, Zip: _____ Fax: _____**
5	**Name: _____ Agency/Relationship: _____** **Address: _____ Phone: _____** **City, State, Zip: _____ Fax: _____**

Prohibition of Redisclosure

This form does not authorize redisclosure of the medical information beyond the limit of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.F Part 2) and state requirements (Iowa Code ch.228) prohibit further disclosure without the specific written consent of the patient or legal guardian, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical and other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

*Only persons 18 years of age or his/her legal representative may authorize release of mental health information.

**Only the subject may authorize release of substance abuse information unless the subject is under legal age or incompetent as defined by statute. Sharing information: It is the responsibility of all agencies listed to provide requested information. The recipient of the information is responsible for maintaining confidentiality of the information