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
- ☐ Immunizations
- ☐ Surgical reports
- ☐ Hospital records
- ☐ Prescriptions
- ☐ Correspondence
- ☐ 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)
- ☐ Individualized education program
- ☐ Appropriate agency reports
- ☐ Individual Education Program (IEP)/Multidisciplinary team evaluations and related reports
- ☐ Psychological evals or social work 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** _____

Please review second page

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 inte1fere 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.

The District does not discriminate in education and employment on the basis of the Protected Classes of race, color, national origin, age, sex (including transgender status, change of sex, sexual orientation, or gender identity), pregnancy, creed or religion, genetic information, handicap or disability, marital status, citizenship status, veteran status, military service (as defined in 111.32, Wis. Stats.), ancestry, arrest record, conviction record, use or non-use of lawful products off the District's premises during non-working and non-learning hours, declining to attend an employer-sponsored meeting or to participate in any communication with the employer and school about religious matters or political matters, or any other characteristic protected by law in its employment and education practices.