CONFIDENTIAL

APPLETON AREA SCHOOL DISTRICT

Release of Information to Exchange Health & Education Information

FERPA and HIPPA compliant

---PLEASE PRINT---

Patient/Student Name: _____ **Date of Birth:** _____

I hereby authorize _____ [*insert health care provider name & title*]

and _____ [*insert name & title of school official*] to exchange health and education information/records for the purpose listed below.

_____ [*insert address & telephone of school/school district*]

_____ [*insert address and telephone of health care provider*]

Description:
The specific health information to be disclosed consists of the following:

The education information to be disclosed:

☐ Progress Records **(please specify)**

☐ Behavior Records **(please specify)**

☐ Health Records **(please specify)**

☐ Patient/Health Care Records **(please specify)**

Purpose: This information will be used for the "coordination of care" (unless specifically stated under "Other" below) and for the following purpose(s):

☐ Educational evaluation and program planning.

☐ Health assessment and planning for health care services and treatment in school.

☐ Medical evaluation and treatment.

☐ Other:_____

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AUTHORIZATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be used or disclosed---I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department or school.

Right to Receive Copy of this Authorization---I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to refuse to sign this Authorization---I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdraw this Authorization---I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department or school. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization is valid for one calendar year. It will expire on _____[*insert date*]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Law (Section 118.125(2m)(a)(b) and 146.81-146.84, Wis. Stats.). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____

Parent Signature Date

_____

Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Wisconsin, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for HIV/AIDS, and family planning services.

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information