PARKWAY SCHOOL DISTRICT
AUTHORIZATION TO USE AND EXCHANGE INFORMATION

By signing this form, I allow agencies to use and exchange certain information about my child, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF AUTHORIZING PERSON OR PERSONS)

_____
(FULL PRINTED NAME OF STUDENT)

_____
(STUDENT'S ADDRESS) *(STUDENT'S BIRTH DATE)* *(STUDENT'S SSN – OPTIONAL)*

My relationship to the student is:
□ Self □ Parent □ Power of Attorney □ Guardian □ Other Legally Authorized Representative

I want the following confidential information about my student to be exchanged:

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
○	○	Assessment Information	○	○	Medical Diagnosis	○	○	Educational Records
○	○	Financial Information	○	○	Mental Health Diagnosis	○	○	Psychiatric Records
○	○	Benefits/Services Needed	○	○	Medical Records	○	○	Criminal Justice Records
○	○	Psychological Records	○	○	Employment Records	○	○	Substance Abuse Records

Other Information (write in):
_____

I hereby authorize
_____
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)
and Parkway School District, Attn:
_____
(NAME AND ADDRESS OF PARKWAY SCHOOL DISTRICT STAFF/CONTACT PERSON)
to exchange the above noted information for the purposes described below:
□ *Yes* □ *No*

I want this information to be exchanged ONLY for the following purpose(s):
□ Service Coordination and Treatment □ Planning □ Eligibility Determination
Other:

_____

I want this information to be shared by the following means: *(check all that apply)*
□ Written Information □In Meetings or By Phone □Computerized Data □Fax

Check One:

□ This authorization is continuing in nature, unless revoked in writing. (See below for information on revoking the authorization.)

□ This authorization is effective _____ until _____
(DATE) *(DATE)*

I can revoke this authorization at any time by sending written notification to both the referring agency and Parkway representative listed above. The listed agency and the District will stop sharing information after receipt of my written notice that this authorization is no longer valid. I have the right to inspect, upon request, what information about me/my child has been shared, and why, when, and with whom it was shared. I want all agencies to accept a copy of this form as valid authorization to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed. However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule. However, I understand that Parkway School District will treat records confidentially and fully comply with The Family Educational Rights and Privacy Act (FERPA) (20 U.S. C. Section 1232g; 34 CFR Part 99) and Parkway Policy JO.BP "Student Records."

Signature(s): _____Date: _____
(AUTHORIZING PERSON OR PERSONS)

Person Explaining Form:

_____
(Name) *(Address)* *(Phone Number)*