

LAFAYETTE SCHOOL CORPORATION  
AUTHORIZATION FOR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION  
AND ACADEMIC RECORDS

Student: \_\_\_\_\_

DOB: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

1. This authorization for the disclosure of protected health information is given pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the associated regulations which govern the privacy of individually identifiable health information (45 C.F.R § 164.500 et seq., as amended), and pursuant to applicable Indiana law.
2. You are hereby authorized to disclose and release to the designated agents of Lafayette School Corporation, 2300 Cason Street, Lafayette, IN 47904 the following:

Records pertaining to \_\_\_\_\_ as indicated below:

_____ School health and Immunization Records	_____ Individual Education Plan (I.E.P)
_____ Office visit note(s)	_____ Individual Health Plan (I.H.P.)/Action Plan
_____ Active medication(s)	_____ Individual Language Plan (I.L.P.)
_____ Psychological testing	_____ Psycho educational evaluations
_____ Therapy note(s)	_____ Classroom behavior
_____ Case Conference Summaries	_____ School Achievement Records

Other: \_\_\_\_\_

I understand that the Protected Health Information in \_\_\_\_\_ medical record may include information relating to Dangerous Communicable Diseases including acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug addiction.

**Patient/Legal Guardian Signature** \_\_\_\_\_

3. The above disclosure is made for the purposes of the treatment of the Student.
4. I understand that Lafayette School Corporation may not require me to sign this authorization as a condition of providing health care treatment for my student. I also understand that this signed consent is required for communication to occur with my student's health care providers.
5. **This authorization shall be valid beginning on \_\_\_\_\_ and shall expire at the end of current school year or when revoked in writing by parent or guardian.**
6. This request is for written records and oral communication between person(s) designated in the section 2 or their representative and the provider(s) Ex. Pediatrician, hospital, doctor, specialist:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. A photocopy of this authorization shall be valid as the original.
8. Notices:
  - a. The individual named below has the right to revoke this authorization by notifying Lafayette School Corporation in writing. After such revocation is delivered to Lafayette School Corporation, no further information will be released pursuant to this Authorization.
  - b. The above-named health care provider may not change treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.

Date: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent or Legal Guardian**

\_\_\_\_\_  
**Printed Name of Parent or Legal Guardian**

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone number (work/home/cell)