Shawano School District

HIPAA-Compliant Authorization for Exchange of Health & Education Information

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

I hereby authorize _____
(insert health care provider name, title, and address)

and _____
(insert name, title of school official and school/school district address)

to exchange health and education information/records for the purpose listed below.

HEALTH INFORMATION TO BE DISCLOSED: *In compliance with Wisconsin Statues, which require special permission for release of otherwise privileged information, please release related to the following:*

- ☐ Medical history and notes
- ☐ Psychological Evaluations or Social Work reports
- ☐ Mental Health Treatment
- ☐ Consults
- ☐ Physical or Occupational Therapy notes
- ☐ Developmental Disabilities
- ☐ Other _____

EDUCATION INFORMATION TO BE DISCLOSED:

- ☐ Official student academic/administrative records (identifying information, grade level completed, grade, class rank, attendance records, and group aptitude and achievement test results
- ☐ Multidisciplinary team evaluations and related reports
- ☐ Psychological Evaluations or Social Work reports
- ☐ Other _____

Purpose: This information will be used for the following purpose(s):

- ☐ Educational evaluation and program planning
- ☐ Medical evaluation and treatment
- ☐ Health assessment and planning for health care services and treatment in school
- ☐ Other _____

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 HIPAA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25(2m)(a)(b) and 146.82-146.83. 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