Authorization to Use and/or Disclose Educational and Protected Health Information

1. I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child.

(Student/Child's Name) _____ (Date of Birth) _____

(Other Names Used by Student/Child) _____ (School or Program Name) _____

Name and address of health care provider authorized to:

✓ Send/disclose protected health information

✓ Receive/use educational information

Name and address of school/EI/ECSE program authorized to:

✓ Send/disclose protected health information

✓ Receive/use educational information

Multnomah Education Service District
11611 NE Ainsworth Circle
Portland, OR 97220

2. I understand that this information will be used for the following purposes (check all that apply):

- ❑ Determining eligibility for Special Education, EI/ECSE, or other services
- ❑ Determining student/child's current levels of performance
- ❑ Developing an individualized health plan
- ✓ Developing an appropriate Individualized Education Program or Individualized Family Service Plan
- ✓ Other (specify): Feeding and swallowing assessments and creation of school feeding plan

3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:

- ❑ Physician's Eligibility Statement
- ❑ Health Assessment Statement
- ✓ History and physical exam
- ❑ Entire medical record
- ❑ Prenatal information
- ❑ Educational Information
- ❑ IFSP/IEP document
- ✓ Clinic records
- ❑ Communicable disease(s)
- ❑ Progress notes
- ❑ Psychological evaluations
- ❑ Social work reports
- ✓ Other: Swallowing assessments, Feeding Clinic evaluations, other relevant notes

4. By *initialing* the spaces below, I authorize the use/disclosure of the following information. Specific records requested must be listed below, e.g., assessment, treatment plan, discharge plan.

___ Drug/alcohol diagnosis, treatment or referral information requested: _____

___ HIV/AIDS related records requested: _____

___ Mental health related information requested: _____

___ Genetic testing information requested: _____

5. By *initialing* the space below, I agree that:

___ The _____ may communicate with Oregon Medical Assistance Programs (OMAP) to determine eligibility
(School/Program Name)
for Medicaid reimbursement for Medicaid-covered services my child may receive in the educational setting.

6. I understand that:

a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care.

b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

c. I may revoke this authorization at any time by notifying Multnomah Education Service District in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

d. Federal privacy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

7. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.

_____
(Signature of Parent, Legal Guardian, Student/Child) (Relationship) (Date)

8. This authorization expires on _____(if blank, assume one year from signing date).
(Month/Day/Year)

AUTHORIZATION TO USE AND/OR DISCLOSE EDUCATIONAL AND PROTECTED HEALTH INFORMATION

Purpose of form:

- This form was created so that educational agencies could request information from health entities that require HIPAA-compliant release forms. (HIPAA: Health Insurance Portability and Accountability Act)

- This form is used when there is a need to obtain consent from a parent, legal guardian or student/child to authorize the named agency to:
  - Send/disclose protected health information and/or educational information; and/or
  - Receive/use protected health information and/or educational information

Directions for completing form:

Box 1. Required.

- Enter the student/child's full legal name including middle name;
- Enter other names used by the child including nicknames;
- Enter child's date of birth;
- Enter the name and address of the health care provider who will send or receive requested protected health and/or educational information;
- Enter the name and address of the school district or EI/ECSE program sending or receiving the requested protected health and/or educational information; and
- Check all appropriate boxes that apply indicating which provider is authorized to send and which provider is authorized to receive protected health and/or educational information.

Box 2. Required.

- Mark all the boxes that apply regarding how the requested protected health and/or educational information will be used. For a record that is not represented in the list, check the "other" box and specify a different type of purpose.

Box 3. Required.

- Mark all the boxes that apply regarding which specific medical and/or educational records are being requested. For a record that is not represented in the list, check the "other" box and specify a different type of record.

Box 4. Required only if any of the four types of records indicated are requested. This box should be left blank if none of these four types of records are requested.

- The four types of records indicated require an additional level of protection. To request any record in Box #4, the specific type of record must be listed in the spaces provided and the parent, legal guardian or student/child must initial the space before each type of record requested. For example, for mental health information, a program might indicate "psychologist's assessment" and then the parent, guardian or student/ child would initial the space at the beginning of the mental health information line.

Box 5. Required only if the form is being used to communicate with the Oregon Medical Assistance Program (OMAP) to determine a child's eligibility for Medicaid. If this is the case, then identify the school or EI/ECSE program seeking the information from OMAP, and ask the parent to initial the space in front of the statement.

Box 6. Required.

- This box contains information relating to the parent's, guardian's, or child's rights in giving authorization including the right to refuse to sign, the right to request a copy after signing, the right to inspect the information to be used and/or disclosed, and the right to revoke the authorization. Information is given that clarifies that when requested information is sent, the laws that protect that information may no longer apply since the receiving agency may not be bound by the same laws as the sending agency.
- In item c., identify who will receive the potential revocation. The statement clarifies that if an action has already been taken, for example, protected health information has already been sent, then the revocation for that specific information is not valid. However, the agency may voluntarily return the information received after the revocation has been signed and submitted.

Box 7. Required.

- Parent, legal guardian, or student/child must sign for the authorization to be valid. If parent or guardian, the relationship to the child must be indicated. The date of the signature must be entered.
- The authorization is only valid for the purposes checked or stated in the form.

Box 8. Required.

- The month, day, and year that this authorization will expire must be included in the space provided. The date must not go beyond one year past the date of the signature.

Additional directions

- Place a copy of this form into the student/child's file.
- HIPAA requires that the school district/EI/ECSE program give a copy of the authorization form to individuals who sign it and request a copy. However, it is recommended practice that the school district/program automatically give the parent, guardian, or student/child a copy of the form after they have signed it, whether or not they request it, so they will have a record of the authorization.