

KILDEER SCHOOL DISTRICT #96

Authorization for Use and Disclosure of Protected Health Information and Education Records

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

I hereby authorize: _____

_____ *[insert name, address, & phone number of individual authorized to disclose records]*

to disclose protected health information and/or educational records to:

_____ *[insert name, address, & phone number of individual to receive records]*

___ Check here if authorization is given for the parties listed above to mutually exchange the information below.

Description:

The medical information to be disclosed consists of (check all that apply):

- ___ Medical history and/or physical ___ Immunization record ___ Lead screening
- ___ Nursing assessment ___ School physical forms ___ Medication records
- ___ Treatment plans ___ TB or other lab results ___ HIV information
- ___ Information related to the following injury or condition: _____

The mental health information to be disclosed consists of (check all that apply):

- ___ Treatment plans ___ Clinical assessments ___ Clinical notes
- ___ Psychiatric evaluations ___ Discharge summaries ___ Treatment notes
- ___ Psychological/Neuropsychological ___ Social assessment/history
- ___ Evaluations
- ___ Records covering the period of time from _____ to _____

The education information to be disclosed consists of (check all those that apply):

- ___ Grades/report cards/transcripts ___ IEPs/504 plans/eligibility documents
- ___ Psychological evaluations ___ Health histories
- ___ Social assessments/histories ___ Speech and language evaluations/reports
- ___ Assistive technology information ___ Behavioral/discipline information
- ___ Neuropsychological evaluations
- ___ Educational testing (local and state assessments)
- ___ Occupational/physical therapy evaluations/reports
- ___ Records covering the period of time from _____ to _____

The substance abuse information to be disclosed consists of (check all those that apply):

- ___ Substance abuse history ___ Treatment, attendance placement and progress
- ___ Discharge/continuing care plan

This authorization is valid for one calendar year and will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their contents.

Parent Signature Date

Student Signature (If student is over 12 years of age and the authorization is for the release of mental health records) Date

Witness Signature Date