School District of Superior
HIPAA – Compliant Authorization for Exchange of Health and/or Educational Information

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

I hereby authorize: _____, Address_____,
Phone Number _____to release my child's health information/records for the purpose listed below to:

_____
Of the School District of Superior
_____School
Address of School_____

Phone Number_____

Fax number_____

Description
The health information to be disclosed consists of:
___Medical and/or related health records
___Psychological evaluations, behavioral assessments and/or social work reports
___Appropriate agency reports (if any)

Purpose: This information will be used for the following purpose(s):
1. Educational evaluation and program planning
2. Health assessment and planning for heath care services and treatment in school
3. Medical evaluation and treatment
4. Other: _____

Authorization
This authorization is valid for one calendar year. It will expire on_____. 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 these 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

Revised: February 2009