Permission to Obtain and Release Information

Sheboygan Area School District
830 Virginia Avenue
Sheboygan, WI 53081
Student and Instructional Services 920/459-3555

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

I hereby authorize _____

_____[*insert health care provider name, address and telephone*] to release my/my child's health information/records for the purpose listed below to:

_____[*insert name/title of school official*]

Sheboygan Area School District_____ [*insert name of school/school district*]

_____ [*insert school address and telephone*]

Description:
The information to be disclosed consists of (dates and/or types of records):
__x__ Medical and/or related health records (including behavioral)
__x__ Psychological, social work, and/or IEP team reports
__x__ Individual Education Program (IEP)
__x__ Verbal communication between providers and school personnel
_____ Other (specify)_____
Purpose:
This information will be used for the following purpose(s):
1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school.
3. Medical evaluation and treatment

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 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 treatment, payment, enrollment or eligibility of benefits.

_____
Parent/Guardian 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.

Photocopy valid as original
Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

Health Records Form – 12/03
Revised 4/11