Plymouth Joint School District
125 Highland Avenue
Plymouth, Wisconsin 53073

Telephone 920-892-2661
Fax 920-892-6366

HIPAA-COMPLIANT AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION

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

I hereby authorize: _____
(name and address of health care provider or school official)

to exchange health and education information/records with:

_____
(name and address of health care provider or school official)

I. **DESCRIPTION:**

The <u>specific</u> health information to be disclosed consists of the following:

_____
_____
_____
_____

The education information to be disclosed:

_____ Progress Records (please specify)_____

_____ Behavior Records (please specify)_____

_____ Health Records (please specify)_____

_____ Patient/Health Care Records (please specify)_____

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

_____ Educational evaluation and program planning.

_____ Health assessment and planning for health care services and treatment in school.

_____ Medical evaluation and treatment.

_____ Other:_____

HIPPA-COMPLIANT AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION

Patient/Student Name: _____ Date of Birth _____

II. AUTHORIZATION

YOUR RIGHTS WITH RESPECT TO THE AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used and Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department or school.

Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Refuse to Sign this Form – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw this Authorization – I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department or school. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this 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 health records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by the Wisconsin Law (Section 118.125(2m)(a)(b) and 146.81-146.84, Wis. Stats.). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____

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.

Copies: Parent (or student), physician or other health care provider releasing the protected health information, school requesting/receiving the protected health information.