Cadott Community Schools

HIPAA-Compliant Authorization for Exchange of Health & Education Information

Patient/Student Name___________________________________**Date of Birth**: ________________________

I hereby authorize ____[*health care provider name & title*] and

Cadott Community Schools, ________________________________[*name & title of school official*] to exchange

Health and education information/records for the purpose listed below.

Cadott Community Schools, PO Box 310, Cadott, WI 54727 715-289-3795, Fax: 715-289-3748 [*address & contact of school/school district*

Description:
The information to be disclosed consists of:

- ☐ Official child academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement assessment results)
- ☐ Medical and/or related health records. Type of Provider:____
- ☐ Medical history/diagnostic/therapeutic information from______________ to______________
  - o Mental Health
  - o HIV
  - o Developmental/Learning Disability
  - o Drug/Alcohol Abuse
- ☐ Specific information (i.e., x-ray films, photographs) or verbal exchange with:___________________________________
- ☐ Medical information limited to____
- ☐ Psychological evaluations or social work reports
- ☐ Evaluation and related reports
- ☐ Appropriate agency reports
- ☐ Attendance, participation, development and/implementation of the IEP
- ☐ Other (specifiy):____

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.
4. Management of health care needs at school.

Authorization

This authorization is valid until rescinded in writing or is no longer a student in the district. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. 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.

____
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.

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