MANITOWOC PUBLIC SCHOOL DISTRICT
Manitowoc, Wisconsin

HIPAA-Compliant Confidential Authorization for Exchange of Health and Education Information - Form to Release/Obtain Information

If returning via fax, send to _____ **Attention** _____

Student/Patient Name: Last, First, Middle Initial

_____

Date of Birth: MM/DD/YYYY

_____

I hereby authorize (health care/service provider/other name & title)

_____

Address, telephone and fax number of health care/service provider/other

_____

and **Manitowoc Public School District Staff**
Central office located at: 2902 Lindbergh Drive, Manitowoc, WI 54220
Office: (920) 686-4777 Fax: (920) 686-4780

Or, if communication can occur with only some individuals, list their information here
(name & title of school staff)

_____

to exchange health and education information/records for the purpose listed below:

_____

The specific health information to be disclosed consists of:

- ❑ Medical and/or related health records
- ❑ Appropriate agency reports
- ❑ Psychological evaluations
- ❑ Verbal exchange of information
- ❑ Other: (Specify below)

_____

The education information to be disclosed consists of:

- ❑ Official student academic/administrative records (identifying info, grade level completed, grades, class rank, attendance, and test results)
- ❑ Psychological evaluations or other official reports from school staff
- ❑ IEP Team evaluations
- ❑ Appropriate agency reports
- ❑ Individualized Education Program
- ❑ Verbal exchange of information
- ❑ Response to medication
- ❑ Behavioral rating scales
- ❑ Nursing assessment letter
- ❑ Progress Records (Specify below)
- ❑ Behavior Records (Specify below)
- ❑ Health Records (Specify below)
- ❑ Other: (Specify below)

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.
- ❑ Determine effectiveness of medication prescribed.
- ❑ Other: (Specify below):

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be used or 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 Authorization – I understand 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 and/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.

Authorization:

This authorization is valid for one calendar year:

Expiration date: _____
MM/DD/YYYY

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 (HIPAA) and may become education records protected by the Family Education Rights and Privacy Act (FERPA) with additional protection afforded by 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.

I am (check one) ☐ the person ☐ the authorized representative of the person whose information is authorized to be used or disclosed.

Parent/Legal Guardian Signature (if applicable)

Date Signed MM/DD/YYYY:

Student Signature* (if student is 18 years old or older)

Date Signed MM/DD/YYYY:

*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.

This form will be uploaded to our student information system. A copy can be supplied to anyone who has a reason to be informed including the parent/guardian.