WISCONSIN RAPIDS SCHOOL DISTRICT

Authorization to Use and Exchange Protected Health and Education Information

Student's Name:_____ **Student Birthdate:**_____

Street Address: _____

City, State,ZIP_____

Authorizes Name of person or organization:	To Exchange Protected health/education information with:
Street Address: City, State, ZIP:	Wisconsin Rapids Public Schools 510 Peach Street Wisconsin Rapids, WI 54494

PROTECTED HEALTH INFORMATION TO BE USED AND EXCHANGED (check all applicable categories)

☐	Medical history and notes	☐	Immunizations	☐	Prescriptions
☐	Assessment summary	☐	Surgical reports	☐	Correspondence
☐	Treatment plan	☐	Hospital records		
☐	X-Ray, EKG, EEG, Lab reports				
☐	By a specific doctor or for a specific diagnosis (specify name of doctor or diagnosis)				
☐	Any and all medical records of the above-named patient relating to the identity, diagnosis, prognosis or treatment of HIV/AIDS (including HIV/AIDS test results), or alcohol and other drug dependency, and of mental health and developmental disability ("Highly Confidential Information")				
☐	Other, specify				

EDUCATION INFORMATION TO BE USED AND EXCHANGED (check all applicable categories)

☐	Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results)
☐	Psychological evaluations or social work reports
☐	Individual Education Program (IEP)/Multidisciplinary team evaluations and related reports
☐	Appropriate agency reports
☐	Individualized education program (records and meeting attendance)
☐	Other (specify)

TIME PERIOD FOR WHICH RECORDS ARE REQUESTED (Check applicable category)

☐ From (date)_____ to _____ ☐ All

PURPOSE OF USE AND EXCHANGE (check applicable category)

☐ Continuing/coordinating health care services ☐ Individual Education Planning/Transitioning and treatment in school

☐ Other, specify_____

EXPIRATION DATE: This authorization will remain in effect (check applicable category)

☐ From the date this authorization is signed until the day_____ of_____ 20_____ .

☐ Until I cancel this authorization in writing.

☐ Until the following event occurs, specify event

☐ Other:

REDISCLOSURE NOTICE: I understand that if the person(s) and/or organizations(s) listed above are not health care providers, health plans or health care clearinghouses, the health/education information exchanged as a result of this authorization may no longer be protected by the Federal privacy standards and my health/education information may be redisclosed by such person(s) and/or organization(s) without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

- **Right to receive copy of this authorization** – I understand that if I sign this authorization, I will be provided with a copy of this authorization.
- **Right to withdraw this authorization** – I understand that if I want to cancel this authorization, I must do so in writing. I understand that my cancellation will not be effective as to uses and/or exchanges of my information that the person(s) and/or organizations(s) listed above have made prior to the receipt of my cancellation form.
- **Right to inspect a copy of the health/education information to be used or exchanged** – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health/education information I have authorized to be used or exchanged by this authorization form. I may arrange to inspect my health/education information or obtain copies of my health/education information by contacting the Health Care Provider or school.
- **Right to refuse to sign this authorization**- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- **HIV test results** – I understand my HIV test results may be released without authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available.
- **Mental health treatment records** – I understand that I have the right to inspect and receive a copy of my mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

In compliance with Wisconsin law, which requires special permission to exchange otherwise privileged information, I specifically authorize the use and exchange of my Highly Confidential Information selected above, if any. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Student signature _____ Date _____

Signature of student's legal representative _____ Relationship to student _____