EAST TROY
COMMUNITY SCHOOL DISTRICT
Committed to the Growth & Success of Each Student, Each Year

AUTHORIZATION FOR USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION

STUDENT INFORMATION

Last Name:_____ First Name:_____ Date of Birth:_____ ☐M ☐F

Address:_____

INSTRUCTIONS: Complete one or both of the Authorization Statements below, place check marks by the information that may be disclosed and sign the authorization. In order to allow the exchange of information between the East Troy Community School District and the identified individual/entity, please check both of the Authorization Statements.

AUTHORIZATION STATEMENTS

☐ I, the undersigned, hereby authorize the East Troy Community School District to disclose by any means the information indicated below regarding the pupil to:

Name:_____ Address:_____ Phone:_____

☐ I, the undersigned, hereby authorize the individual, health care provider, organization or agency listed below to disclose by any means the information indicated below to the East Troy Community Schools.

Name:_____ Address:_____ Phone:_____

Type of Health Care Provider Making the Disclosure:_____

The confidential information that may be disclosed (including paper, oral, and electronic interchange) under the authorization includes:

☐ All protected health information as defined by the federal Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations and patient health care records as defined by Wis. Stat. §146.81, including information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug use. If a minor student is authorized to consent to health care without parental consent under federal or state law, the student may 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.

☐ All education records as defined in the federal Family Educational Rights and Privacy Act (FERPA) and pupil records as defined in Wis. Stat. §118.125.

☐ Only the information described below:

☐ All psychiatric and psychological reports ☐ All education testing reports

☐ All social work reports ☐ Other:_____

The purpose for this authorization is:_____

ACKNOWLEDGEMENTS

Receive Records & Authorization- I understand that I have a right to a copy of the records that are disclosed and a right to a copy of this authorization.

Withdrawal of Authorization- I understand that I have a right to revoke this authorization, except to the extent that disclosure has already been made in reliance on this authorization. I understand that my revocation is effective only if it is in writing and it is submitted to the individual/entity that is releasing information.

Re-Disclosure of Health Information- I understand that if my child's health information is released pursuant to this authorization, it may be subject to re-disclosure by a person who receives the health information and may not be protected by federal law.

Voluntary Authorization- I understand that a health care provider may not condition health care treatment, payment or eligibility for health plan benefits on whether or not I sign this authorization.

AUTHORIZATION SIGNATURE

This authorization expires one (1) year after the pupil is no longer enrolled as a pupil at East Troy Community Schools. The signer may revoke this authorization at any time in writing by sending a letter addressed to the individual or entity authorized by this form to disclose confidential information which specifically revokes this authorization, except to the extent that action has been taken in reliance on this authorization. If disclosure authorized by this form is to be made by East Troy Community School District, notice of revocation should be made to the East Troy Community School District. A photocopy of this authorization shall be as valid as the original.

Signature:_____ Date:_____

Parent/Guardian; Eligible Pupil (i.e., pupil 18 or over); or Minor Authorized to Consent