

# WAUSAU SCHOOL DISTRICT

## Authorization to Use and Exchange Protected Health and Education Information

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

<p><b>Authorizes</b> Name of person or organization: _____</p> <p>_____</p> <p>Street Address: _____</p> <p>City, State, ZIP _____</p>	<p><b>To Exchange</b> Protected health/education information with:</p> <p>Wausau School District - School: _____</p> <p>Contact Person: _____</p> <p>Street Address: _____</p> <p>City, State, ZIP _____</p>
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**PROTECTED HEALTH INFORMATION TO BE USED AND EXCHANGED** (check all applicable categories)

<input type="checkbox"/>	Medical history and notes	<input type="checkbox"/>	Immunizations	<input type="checkbox"/>	Prescriptions
<input type="checkbox"/>	Assessment summary	<input type="checkbox"/>	Surgical reports	<input type="checkbox"/>	Correspondence
<input type="checkbox"/>	Treatment plan	<input type="checkbox"/>	Hospital records		
<input type="checkbox"/>	X-Ray, EKG, EEG, Lab reports				
<input type="checkbox"/>	By a specific doctor or for a specific diagnosis (specify name of doctor or diagnosis)				
<input type="checkbox"/>	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")				
<input type="checkbox"/>	Other, specify _____				

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

<input type="checkbox"/>	Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results)
<input type="checkbox"/>	Psychological evaluations or social work reports
<input type="checkbox"/>	Individual Education Program (IEP)/Multidisciplinary team evaluations and related reports
<input type="checkbox"/>	Appropriate agency reports
<input type="checkbox"/>	Individualized education program
<input type="checkbox"/>	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 and treatment in school  Individual Education Planning/Transitioning

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 \_\_\_\_\_.

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

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**REDISCLASURE 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 refuse to sign** – I understand that refusal to sign, will not interfere with my child's ability to obtain health care.
- **Right to withdraw this authorization** – I understand that if I want to cancel this authorization, I must do so in writing. To obtain a form to cancel this authorization, I may contact the Wausau School District. 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.
- **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.