SCHOOL DISTRICT OF LODI

Authorization to Release, Obtain, and/or Exchange Information

HIPAA – Compliant Authorization

(Ref. Policy No. 533.1 – Student Records)

STUDENT:

(Name of Student) (D.O.B.)

(Street Address)

(City, State, Zip Code)

I HEREBY AUTHORIZE:

(Name of Previous School or Health Care Provider)

(Street Address)

(City, State, Zip Code) (Phone No.) (Fax)

To ☐ **obtain from** ☐ **release to** and/or ☐ **exchange** my child's health information and school records with the School District of Lodi. Mail records to:

☐ District Office 115 School Street Lodi, WI 53555 Phone: 608/592-3851 Fax: 608/592-3852 Attn: Kris Wendorf	☐ **Lodi Primary School** 103 Pleasant Street Lodi, WI 53555 Phone: 608/592-3855 Fax: 608/592-1015	☐ **Lodi Elem. School** 101 School Street Lodi, WI 53555 Phone: 608/592-3842 Fax: 608/592-1025	☐ **Lodi Middle School** 900 Sauk Street Lodi, WI 53555 Phone: 608/592-3854 Fax: 608/592-1035	☐ **Lodi High School** 1100 Sauk Street Lodi, WI 53555 Phone: 608/592-3853 Fax: 608/592-1045

This disclosure is being made for the following purpose(s):

☐ Educational Planning
☐ School Related Health Information
☐ Further Medical Information Needs
☐ At the Request of an Individual
☐ Other:

Information to be Released:

☐ Official Student Academic/Admin Rpt.
☐ IEP Team Evals. & Related Reports
☐ Current IEP and Eligibility
☐ Social Work Report
☐ Appropriate Agency Reports
☐ Progress Notes
☐ Info. Necessary for Continued Care
☐ Medical History & Physical
☐ Discharge Summary
☐ Immunizations
☐ OT/PT/SP Therapy Notes
☐ Other : _____

In compliance with Wisconsin Statutes that require special permission to release otherwise privileged information, please release records pertaining to:

☐ Mental Health & Psych. Reports & Testing (initial intake & progress notes)
☐ Phone Consultation
☐ Drug Abuse or Test Results
☐ Sexually Transmitted Disease
☐ Other_____

REDISCLOSURE NOTICE - I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer protected by Federal Privacy Standards.

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. This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits except for: ☐ No Exceptions ☐ Exceptions (specify):

RIGHT TO RECEIVE COPY OF THIS AUTHORIZATION - I understand I am under no obligation to sign this form. The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Act and may become education records protected by the Family Educational Rights Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25 (2m)(a)(b) and 146.82-146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

RIGHT TO REVOKE - I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information. Unless revoked, this authorization will remain in effect for one year.

EXPIRATION DATE - This authorization is valid for one year from the date signed. A copy of this form is as effective as the original. 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.

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

Signature of Parent/Legal Guardian or Adult Student: _____ **Date:** _____

Relationship to student (if a minor):