Schiller International University
HIPAA/FERPA –Authorization for Exchange of Education & Health Information

Patient/Student Name: _____ Date of Birth: _____
I hereby authorize:

_____

(insert health care provider: **name, title, address, & telephone**)

and **Attn: Campus Director, Schiller International University, 8560 Ulmerton Road, Largo FL, 33771,** to exchange health and education information/records for the purpose listed below.

_____

Description:

Authorization for phone and email communication or written reports related to:

Disclosure or the following health and/or agency information:

1. Disability diagnosis
2. History of the student's disability and previous accommodations
3. Affect of the student's disability on the student's performance of activities within his or her educational program.
4. Current needs in an educational and career setting in relation to the student's disability
5. Appropriate agency reports

Disclosure of the following educational information:

1. Student's program, attendance, academic assessment and progress Schiller International University
2. IEP Team evaluations, IEP plans, and related reports from K-12 schools

This information will be used for the following purpose(s):

1. Assessment and approval of appropriate disability related educational accommodations.
2. Other: _____

Authorization

This authorization is valid for one calendar year. It will expire on _____ (insert date). 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 college, may not be protected by the HIPAA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA).

_____

Student Signature Date

_____

Parent Signature* Date

*Required if student is a minor.