

Sheridan School District 48J
AUTHORIZATION TO USE AND/OR DISCLOSE EDUCATIONAL AND PROTECTED HEALTH INFORMATION

1. I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child.

Student/Child's Name

Date of Birth

Other Names Used by Student/Child

Sheridan School District 48J

School or Program Name

Name and address of health care provider/doctor authorized to:

☐ Send/disclose protected health information

☐ Receive/use educational information

Name and address of school authorized to:

☐ Send/disclose educational information

☐ Receive/use protected health information

Sheridan School District 48J

435 S. Bridge St., Sheridan, OR 97378

2. I understand that this information will be used for the following purposes (check all that apply):

☐ Determining eligibility for Special Education or other services

☐ Determining student/child's current levels of performance

☐ Developing an individualized health plan

☐ Developing an appropriate Individualized Education Program

☐ Other (specify): _____

3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:

☐ Physician's Eligibility Statement

☐ Health Assessment Statement

☐ History and physical exam

☐ Entire medical record

☐ Prenatal information

☐ Educational Information

☐ IEP document

☐ Clinic records

☐ Communicable disease(s)

☐ Progress notes

☐ Psychological Evaluations

☐ Social work reports

☐ Other: _____

4. By initialing the spaces below, I authorize the use/disclosure of the following information. Specific records requested must be listed below, e.g., assessment, treatment plan, discharge plan.

_____ Drug/alcohol diagnosis, treatment or referral information requested: _____

_____ HIV/AIDS related records requested: _____

_____ Mental health related information requested: _____

_____ Genetic testing information requested: _____

5. I understand that:

a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care.

b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR 164.524)

c. I may revoke this authorization at any time by notifying Sheridan School District 48J in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

d. Federal policy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

6. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.

Signature of Parent/Legal Guardian/Student/Child

Date

Relationship

This authorization expires (month/day/year) (not to exceed one year from date of signature above)