Authorization to Use/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 name used by student/child) (School or Program Name)

   Name and address of health care provider authorized to send/disclose protected health information:

   ______________________________ **Attention:** ______________________
   ____
   ______________________________**Fax number:** ______________________

   Name and address of school program authorized to receive protected health information:

   ______________________________**Attention:** ______________________
   ____
   ______________________________**Fax number:** ______________________

2. **I understand that the 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, Section 504 plan or academic/behavior interventions
   _____ Other: ______________________________

3. **By marking the boxes below, I authorize the use/disclosure of the following records:**
   _____ Physician's Eligibility Statement _____ Educational Information _____ Psychological evaluation
   _____ Health Assessment Statement _____ IFSP/IEP document _____ Social work reports
   _____ History and Physical Form _____ Clinic records _____ Other: ____________
   _____ Entire Medical record _____ Communicable Disease(s) ________________
   _____ Prenatal information _____ Progress notes

4. **By initialing the spaces below, I authorize the use/disclosure of the following information. Specific records must be listed below, e.g. assessment, treatment, 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. **By initialing the space below, I agree that:**
   _____ The ____________________ may communicate with MS Medical Assistance Programs to determine eligibility for Medicaid reimbursement for medicaid-covered services my child may receive in the educational setting.

6. **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 a 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.
   c. I may revoke this authorization at any time by notifying ____________________ in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on shared information.
   d. Federal privacy 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 educational information apply only to school 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.

7. **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) (Relationship) (Date)

8. **This authorization expires on ____________________ (not to exceed one year from date of signature).**