WEST SALEM SCHOOL DISTRICT

Authorization for Release of Health Information

Patient/Student Name: _____ **Date of Birth:** _____

I hereby authorize:_____

[*insert health care provider name, address and telephone*] to release my/my child's health information/ records for the purpose listed below to:

_____ [*insert name of school official*]

West Salem School District
450 N. Mark Street
West Salem, WI 54669
phone 608-786-0700 fax 608-786-2960

Description:
The information to be disclosed consists of:

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

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 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 and Privacy 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.

_____
Parent Signature Date

_____
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Wisconsin, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for HIV/AIDS, and family planning services.

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information