School District of Holmen
1019 McHugh Road
Holmen, WI 54636
608.526.6610

Authorization to Release Protected Information

Student Name (First, Middle, Last)**:** ______________________________________ **Date of Birth:** ____________

I hereby authorize the release/obtaining of information between:

	School District of Holmen
Agency: ______________________________________	School: ____________________
Address: _____________________________________	Address: ______________________
Phone/Fax: ___________________________________	Phone/fax: ____________
Authorized Rep.: _______________________________	Authorized Rep: ________________________

Purpose of Release

___Verbal Communication ___Written communication
___Student educational programming ___ Disability Determination ___Individual Health Plan/Medical
___Other (specify): ___________________________________

Information to be Released

___Student academic records (i.e. grades, achievement test results, IEP evaluations, etc.)
___Behavioral records (i.e. staff managed and office referrals, Educational Support Team (EST) reports, etc.)
___Medical information
___Mental health ___Developmental disability ___Alcohol/Drug Abuse
___Individualized Education Program (IEP) Plan
___Appropriate agency reports (i.e. psychological evaluations, social work report, lab reports, etc.)
___Other (specific health information to be released): ____

Authorization & Your Rights

Federal and state laws protect the confidentiality of PHI including but not limited to: Mental Health – Sec 51.30, Wis Stats: & HFS 92, Wis Admin. Code, Alcohol & Other drug Abuse-Sec. 5130 Wis. Stats, HF92, Wis Admin. Code: and 42 CFR Part 2 Final Rule governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties.
I have a right to receive a copy of this form after I sign it.
If I authorize release of PHI to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my PHI may not remain confidential.
This authorization is valid through the duration of time indicated below. A copy of this form is as effective as the original. 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, except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.
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 this authorization, such refusal may not condition my child's treatment, payment, enrollment or the eligibility of benefits; nor will refusal to sign this authorization interfere with my child's ability to obtain educational services. I have the right to inspect and receive copies of my personal health information by law.

Expiration Date: This authorization is valid for 1 year from date of signature or until _____________ (specific date up to 2 years) and covers records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until the expiration dates.

______________________________________	_______________________________	_______________
Parent/Guardian/Adult Student Signature	**Relationship to Student**	**Date**

Copies: **1) School/Agency** **2) Parent/Guardian/Student** **3) Student file**

Revised January 2015