MOUNT HOREB AREA SCHOOL DISTRICT
Mount Horeb, Wisconsin

PERMISSION TO OBTAIN AND RELEASE INFORMATION

STUDENT:

(Name of Student) ____________________ (Date) ____________________

(Street Address) ____________________ (Birth Date) ____________________

(City, State, Zip Code) ____________________

AUTHORIZES:

(Name of Provider) ____________________

(Street Address) ____________________

(City, State, Zip Code) ____________________

RELEASE OF PROTECTED INFORMATION TO X FROM X

Mount Horeb High School
(Name)

305 S. 8th St.
(Street Address)

Mount Horeb, WI 53572
(City, State, Zip Code)

This disclosure is being made for the following purpose(s):

- ◻ Qualification for Individualized Education Plan
- ◻ School Related Health Information
- ◻ Further Medical Information Needs
- ◻ At the Request of an Individual
- ◻ Other ____________________

Information to be Released:	Date of Service		Date of Service
◻ Official Student Academic/Admin Rprt.		◻ History & Physical	
◻ IEP Team Evals & Related Reports		◻ Discharge Summary	
◻ Social Work Report		◻ Operative/Procedure Report	
◻ Appropriate Agency Reports		◻ Immunizations	
◻ Progress Notes		◻ EKG/EMG/EEG	
◻ Info. Necessary for Cont. Care		◻ PT/SP/OT	
◻ Other		◻ Labs	

In compliance with Wisconsin and Minnesota Statutes that requires special permission to release otherwise privileged information, please release records pertaining to:

- ◻ Mental Health & Psych. Reports & Testing (initial intake & progress notes)
- ◻ Phone Consultation
- ◻ Drug Abuse or Test Results
- ◻ Sexually Transmitted Disease
- ◻ Other ____________________

REDISCLOSURE NOTICE - I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer protected by Federal Privacy Standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

RIGHT TO INSPECT OR COPY THE HEALTH INFORMATION TO BE USED OR DISCLOSED – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits except for: No Exceptions Exceptions (specify):

RIGHT TO RECEIVE COPY OF THIS AUTHORIZATION - I understand I am under no obligation to sign this form. The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws. I recognize that these records, once received by the school district, may not be protected by the HIPSS Privacy Act and may become education records protected by the Family Educational Rights 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.

RIGHT TO REVOKE - I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information. Unless revoked, this authorization will remain in effect for one year.

EXPIRATION DATE - This authorization is valid for one year from the date signed. A copy of this form is as effective as the original. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

SIGNATURE – Student (14 Years of age or older)		Date Signed
SIGNATURE – Other Person Legally Authorized to Consent to Disclosure	Title or Relationship to Individual who is the Student	Date Signed

Revised 1/13/12