COOPERATIVE EDUCATIONAL SERVICES

HIPPA-Compliant Authorization for Exchange of Health and Education Information

Form 2A

Patient/Student Name: ______________________________ **Date of Birth** ______________

I hereby authorize ____
(Health Care Provider Name, Address and Telephone Number)

To release my/my child's health information/records for the purpose listed below to:

______________________________ ______________________
(Name and title of school official) (Telephone number)

____
(Name and address of school)

Description:

The health information to be disclosed consists of:
Medical history and immunizations including diagnosis/goals/treatments.
Psychiatric regarding diagnosis/treatment and medication intervention.
Other: ______________________________

The education information to be disclosed consist of:
Progress and achievement reports.
Behavioral data and information.
Individualized Education Plan
Other: ______________________________

Purpose:

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

1. Educational Evaluation and program planning
2. Health assessment and planning for health care services and treatment in school
3. Medical evaluation and treatment
4. Assessment and planning for treatment of psychiatric, emotional and social needs
5. Other____

Authorization

This authorization is valid for one calendar year. It will expire on ______________. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPPA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

____
Parent or Guardian 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 Connecticut, a competent minor, depending on age, can consent to outpatient mental healthcare, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.

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