South Central Community School Corporation
9808 South 600 West | Union Mills, IN 46382
Phone: 219-767-2263 | Fax: 219-767-2260 | www.scentral.k12.in.us
Home of the Satellites!

Compliant Authorization for Exchange of HIPAA & FERPA Records

Patient/Student Name: _____ **DOB:** _____

Health Care Provider Name & Title: _____

Health Care Provider Address & Phone: _____

School Name: _____

School Address & Phone: _____

I/We hereby authorize the above health care provider and school to disclose protected health and education information/records for the purpose listed below.

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

- ☐ Educational evaluation and program planning
- ☐ Health assessment and planning for health care services and treatment in school
- ☐ Medical evaluation and treatment
- ☐ Other: _____

Description:
The health information to be disclosed consists of:

- ☐ Entire medical record
- ☐ Dates of treatment, progress notes, diagnosis, treatment plan, and medication schedule
- ☐ Consultation reports
- ☐ Discharge summary
- ☐ Laboratory results, test results
- ☐ History and physical
- ☐ Mental health records
- ☐ Substance abuse records
- ☐ Other: _____

The education information to be disclosed consists of:

- ☐ All educational records, including special education records and family contacts
- ☐ Grades, teacher reports
- ☐ Attendance & discipline
- ☐ Special education evaluations, placement, and progress
- ☐ Contacts with the school nurse, social worker, or counselor
- ☐ Contacts with the family
- ☐ Other: _____

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 a 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 HIPAA 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/educational services. I agree that a copy of this release shall be as valid as this original release.

Parent/Guardian Signature: _____ **Date:** _____