Authorization to Use/Disclose Educational and Protected Health Information

1.	I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child.
	(Student/Child's Name) (Date of Birth)
	(Other name used by student/child) (School or Program Name)
	Name and address of health care provider authorized to send/disclose protected health information:
	Attention:
	Fax number:
	Name and address of school program authorized to receive protected health information: Attention:
	Fax number:
2.	I understand that the information will be used for the following purposes (Check all that apply):
	Determining eligibility for Special Education or other services
	Determining student/child's current levels of performance
	Developing an Individualized Health Plan
	Developing an appropriate Individualized Education Program, Section 504 plan or academic/behavior interventions Other:
3.	By marking the boxes below, I authorize the use/disclosure of the following records:
	Physician's Eligibility Statement Educational Information Psychological evaluation
	Health Assessment Statement IFSP/IEP document Social work reports
	History and Physical Form Clinic records Other:
	Entire Medical record Communicable Disease(s)
4.	Prenatal information Progress notes By initialing the spaces below, I authorize the use/disclosure of the following information. Specific records must be
	Drug/alcohol diagnosis, treatment, or referral information requested: HIV/AIDS related records requested: Mental health related information requested: Genetic testing information requested:
5.	By initialing the space below, I agree that:
	The may communicate with MS Medical Assistance Programs to determine eligibility
	for Medicaid reimbursement for medicaid-covered services my child may receive in the educational setting.
6.	I understand that:
	a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care.b. I have a right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or
	disclosed under this authorization.
	c. I may revoke this authorization at any time by notifying in writing. However, it will not affect
	any actions taken before the revocation was received or actions taken based on shared information.
	d. Federal privacy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.
	e. Federal privacy rules for educational information apply only to school programs. If I authorize disclosure of
	educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.
7.	I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons
	other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.
	(Signature of Parent, Legal Guardian, Student/Child) (Relationship) (Date)
8.	This authorization expires on (not to exceed one year from date of signature).