Elkhorn Area School District
CONSENT FOR RELEASE OF INFORMATION/RECORDS

I give permission for the release of information between:

Elkhorn Area School District 3 North Jackson Street Elkhorn, WI 53121 Phone: 262-723-3160 Fax: 262-723-3124	-AND-	Agency Name: Address:
School: School Phone: School Fax:		Phone: Fax:

Records pertaining to: Name: _____Date of Birth: _____

The release of the following written and verbal information is authorized:

☐ Physical health records
☐ Psychosocial history
☐ Psychiatric evaluation
☐ Psychological evaluation
☐ Physicians orders
☐ Treatment planning
☐ Treatment schedule
☐ Discharge summary
☐ School progress records
☐ School attendance records
☐ School standardized test results
☐ School health and immunization records
☐ School disciplinary records
☐ Special Education evaluation, placement, progress records
☐ Alcohol and drug evaluation and/or treatment records
☐ Other_____

This information may be released and is necessary for the purpose(s) of:

☐ For the development of educational planning
☐ For the development of health care planning
☐ Other_____

_____ _____
Parent or Guardian Date

_____ _____
Youth (if necessary) Date

_____ _____
School Representative and Title Date

This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period. If you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.

☐ **This authorization shall expire no later than one year from the signature date.**
☐ Other specific expiration date or event (specify):_____

****PLEASE READ AND INITIAL THE BACK SIDE OF THIS PAGE****

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Patients have a right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authority.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, health care providers may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organizations(s) listed on the reverse side of this form have already made, in reliance on this authorization before the time you revoke it. In addition, this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to the provider listed on the front of this form.

Re-release. If the person(s) and/or organization authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the patient accounting or medical records department of the health care provider where you received medical or other care.

Multiple Releases of Information. A patient may request multiple releases of information stated on the Authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A new Authorization is necessary for release of information for care provided after the date of the patient's signature, unless the Authorization specifically states that specific records that will be generated in the future may be released, for example, "future records for a specific test" or "future records for a specific clinic appointment."

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you.

Fees for Records. The provider may charge a reasonable fee for copying and postage to fulfill this request. All fees are based on applicable laws governing release of health information.

Please initial that you have read the above paragraphs: _____