PERMISSION TO OBTAIN AND RELEASE INFORMATION

PARENT PERMISSION TO OBTAIN AND RELEASE INFORMATION (two way communication)

I, the undersigned, hereby request and authorize:

School/Agency: School District of Mauston (608) 847-5451 phone (608)847-4635 fax

Address: 510 Grayside Avenue,
Mauston, Wisconsin 53948

Contact Person: _____

Innervisions Counseling & Consulting Center S.C.

*This form is required for your child to be seen at the school.

To release to or obtain from:

School/Agency/Foster Parent/Other: _____

Address: (Include City, State, Zip) Phone & Fax

_____

_____

The information, which I have indicated below:

Name of Child: _____

Date of Birth: _____

- ☐ Official child academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement assessment results)
- ☐ Medical and/or related health records. Type of provider _____
- ☐ Medical history/diagnostic/therapeutic information from _____ to _____ including:
  ☐ Mental Health ☐ HIV ☐ Developmental/ Learning Disability ☐ Drug/Alcohol Abuse
- ☐ Specific information (i.e., x-ray films, photographs) or verbal exchange with:
- ☐ Medical information limited to: _____
- ☐ Psychological evaluations or social work reports
- ☐ Evaluation and related reports
- ☐ Appropriate agency reports
- ☐ Exchange/release of the IEP documentation
- ☐ Attendance, participation, development and/implementation of the IEP
- ☐ Verbal exchange
- ☐ Other (specify) : _____
- ☐ Purpose of disclosure : **Aid in student's educational programming**

***This permission is valid for one year from the date signed. A copy of this form is as effective as the original.**

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. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department or school.
Right to Receive Copy of this Authorization---I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
Right to refuse to sign this Authorization---I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
Right to withdraw this Authorization---I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department or school. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district, may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statues 118.25(2m)(a)(b) and 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.

Signature of parent / relationship **Date**

The school district does not discriminate on the basis of race, sex, age, religion, disability, or national origin.