HIPAA Compliant Authorization for Exchange of Health & Education Information

Patient/Student Name: ____**Date of Birth:** _____________________

I hereby authorize (insert health care provider name & title)____

STREET: ____

CITY: ____ STATE: ____________ ZIP: ________________

PHONE: _______________________________________ FAX: ____

To exchange health and education information/records for the purpose listed below with (insert names and titles of school officials) ____

STREET: ____

CITY: ____ STATE: ____________ ZIP: ________________

PHONE: _______________________________________ FAX: ____

Purpose

The health information to be disclosed consists of (check applicable boxes):

- ☐ Physical Exam (most recent)
- ☐ Statement of the current diagnosis and treatment including orders of treatments needed at school
- ☐ Immunization Records
- ☐ Reciprocal sharing of information pertinent to diagnosis, academic needs, or progress
- ☐ Other health records (Please specify)____

The education information to be disclosed consists of (check applicable boxes):

- ☐ School Cumulative Records
- ☐ Confidential (sensitive) Records
- ☐ Current Report Card
- ☐ Special Education
- ☐ Reciprocal sharing of information relevant to educational needs
- ☐ Other (Please specify)____

This information will be used for the following purposes:

1. Health assessment and planning to ensure safe health care services and treatments at school
2. Education evaluation and program planning
3. Other: ____

Authorization

This authorization is valid for the school year, 20____-20____and/or will expire on ________________(insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of consent. I recognize that health records, once received by the school district, will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I further understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

PARENT/GUARDIAN: ____
Signature Date

STUDENT (If Applicable*) ____
Signature Date

*Student age 18 or older.

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

Rev. January 2022

Notification Statement of Non-discrimination:

The Olathe Public Schools prohibit discrimination on the basis of race, color, ethnicity, national origin, sex, disability, age, religion, sexual orientation or gender identity in its programs, activities or employment, and provides equal access to the Boy Scouts and other designated youth groups to its facilities as required by: Title IX of the Education Amendments of 1972, Title VI and Title VII of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act (ADA), the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973, the Equal Access Act of 1984 and other relevant state and federal laws as amended. Inquiries regarding compliance with applicable civil rights statutes related to race, ethnicity, gender, age discrimination, sexual orientation, gender identity or equal access may be directed to Staff Counsel, 14160 S. Black Bob Road, Olathe, KS 66063-2000, phone 913-780-7000. All inquiries regarding compliance with applicable statutes regarding Section 504 of the Re-habilitation Act and the Individuals with Disabilities Education Act and the Americans with Disabilities Act may be directed to the Assistant Superintendent of Support Services, 14160 S. Black Bob Rd. Olathe, KS 66063-2000, phone 913-780-7000. Interested persons including those with impaired vision or hearing, can also obtain information as to the existence and location of services, activities and facilities that are accessible to and usable by disabled persons by calling the Assistant Superintendent of Support Services. (1/22)