Authorization for the Release of Health and/or Educational Information

Student Name: ______________________________ **Birthdate:** ____/____/____

Address: ______________________________ **Phone:** ______________

____

On behalf of the above named student, I authorize ______________________________
(name of health care provider, agency, or medical institution)

to release evaluation records to ______________________________
(School District)

for the purpose of determining eligibility for and/or provision of Section 504.

District Contact: ______________________________

District Address: ______________________________

For this purpose, I consent to the release of the following health information to the school district regarding this child from

____/____/____ to ____/____/____ :

- ☐ Current Medical Status
- ☐ Current Medications/treatments
- ☐ Recommendations for School
- ☐ Other ______________________________

I hereby give special permission to the above named medical entity to release records pertaining to:

- ☐ Mental health
- ☐ Substance abuse/chemical dependence
- ☐ Sexually transmitted disease
- ☐ HIV/AIDS

I understand that the released information becomes a part of the student's educational records and, as such, is protected by the Family Educational Rights and Privacy Act (FERPA). The information may be reviewed by all members of the Section 504 team and, as appropriate, those identified as having legitimate educational interest. The information may also be used in the future, including if the student moves, for the purpose of educational decision making.

I understand that I have the following **rights** with respect to this authorization:

- The right to inspect or copy the health information to be disclosed by this form.
- The right to receive a copy of this form.
- The right to withdraw this Authorization by written notification at any time (although my withdrawal will not be effective as to uses and/or disclosures already made regarding this form).

This authorization is valid until ____/____/____ , or until one year after the date of signing, whichever occurs first.

______________________________ ______________________________ ____/____/____
Signature Relationship to Student Date

____
Printed name

**Health Insurance Portability and Accountability Act (HIPAA)/
Family Educational Rights and Privacy Act (FERPA) Notice**

Any and all personally identifiable information regarding children and families is protected from unauthorized disclosure under FERPA. Personally identifiable information protected by FERPA is specifically **exempted** from HIPAA privacy standards. FERPA prohibits disclosure of personally identifiable information without parent consent except in limited circumstances, requires notice to be provided to the child's family regarding their privacy rights, requires providers to keep records of access to a child's records, and contains complaint and appeal procedures which apply to disputes over records.

NOTICE TO RECIPIENTS OF MENTAL HEALTH INFORMATION

In accordance with the Iowa Mental Health Information Disclosure Act (Iowa Code, Chapter 228), a recipient of mental health information may redisclose this information only with the written authorization of the subject or the subject's legal representative or as otherwise provided in chapter 228 and 220. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE TO RECIPIENTS OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed from records whose confidentiality is protected by Federal law. Iowa Code, Chapter 125 and Federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written consent of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE TO RECIPIENT OF HIV RELATED TESTING INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code 141.23) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.