

**Northwest Kansas Educational Service Center and USD _____
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Print Student's Full Name: _____

Birthdate: _____ Social Security Number: _____

Telephone: _____

I, _____, authorize _____

to disclose confidential health information from the above-named patient's/client's health records to the student's confidential school file and (name) _____ for the following purpose: _____.

The information to be disclosed/released/or exchanged is:

- | | |
|---|--|
| <input type="checkbox"/> Consultation Reports/Records | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> Counseling Notes/Reports/Records |
| <input type="checkbox"/> Medication Reports | <input type="checkbox"/> Social Work Reports/Records |
| <input type="checkbox"/> Physical/Speech/Occupational Therapy Records | <input type="checkbox"/> Oral communications concerning educational programming and/or therapy |
| <input type="checkbox"/> Physician Notes/Records/Orders | |

for treatment dates of _____.

I understand that the health information may contain information relating to: contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law, and I authorize disclosure of that information. I understand that once the health information has been disclosed to NKESC the records are considered educational records covered under the Family Educational Rights and Privacy Act (FERPA).

NOTICE: It is the policy of the Northwest Kansas Educational Service Center/Member Districts, in accordance with the Individuals with Disabilities Education Act (IDEA), to permit the parent of a student who has been referred for evaluation, or the student who has been certified to receive special services by the local district's evaluation team, to inspect and review the educational records of the student. Any information which is received, relating to and used to make educational decisions regarding a student, will become a part of the student's record, and thus, will be subject to disclosure to the parent or eligible student and, as authorized by signature below, be released to other agencies.

I understand that I may see and copy the information described on this form as provided by federal regulations, and that I will get a copy of this form after I sign it.

This authorization will expire on the following date or event: _____

I understand that I can revoke this authorization in writing, but that any revocation is not effective for disclosures that have already been made. To revoke this authorization, I should contact:

Northwest Kansas Educational Service Center
Attn: HIPAA Agency Officer or Director of Special Education
703 West Second
Oakley, KS 67748

Signature of Parent/Guardian/or Emancipated Student

Date

Witness Signature

Date

Witness Signature

Date