FERPA/HIPAA CONSENT FOR RELEASE OF INFORMATION
AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICAL PROVIDERS and WHD 147

Student Name: ____DOB: ____________________
I, the undersigned, do hereby authorize (name of agency and/or health care providers):
(1)____
(2)____
to provide protected health information from the above-named child's medical record to and from: West Harvey Dixmoor School District 147

Contact Person at School District:____________________________________
Telephone Number: ____________________________Fax Number:_____________________
The disclosure of health information is required for the following purpose:
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Requested information shall be limited to the following dates of service:
From:______To: ______:
❏ Medical Records (Immunizations___ Physician notes___ Imaging reports___ Other_____)
❏ Psychological / Social Worker Reports
❏ Therapy Reports (Speech___ Occupational___ Physical___ Developmental___
❏ Other:
____

DURATION:
Unless revoked, this authorization will expire 30 days from the date of the signature on the authorization. For mental health purposes, this authorization will expire one year from the date of signature.

RESTRICTIONS:
Law prohibits WHD 147 from making further disclosure of my health information unless WHD 147 obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:
I understand that I have the following rights with respect to this Authorization: I may revoke this

Authorization at any time. My revocation must be in writing, signed by me, and delivered to the WHD 147 District. My revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

RE-DISCLOSURE:

I understand that the Requestor (WHD 147) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information may be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure. I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this Authorization.

I have a right to receive a copy of this Authorization. I have read and understand the terms of This Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information.

APPROVAL:

Printed Parent/Guardian Name

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Signature ____

Relationship to Student _________________________________ Date _______________

Signature of Patient age 12 or over ______________________________________

Date _______________

Witness ____ Date ___________

Witness is required for mental health releases.