



ANW Special Education Cooperative

710 Bridge Street, P.O. Box 207
Humboldt, KS 66748
Phone: (620) 473-2257 Fax: (620) 473-2159

Serving Allen, Anderson, Neosho, Wilson & Woodson Counties

HIPPA Compliant Authorization for Exchange of Health & Education Information

Patient/Student Name: _____

Date of Birth: _____

I hear by authorize: _____ (insert health care provider/agency name & title)

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ FAX: (_____) _____

AND



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To exchange health and education information/records with each other for the purposes listed below:

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

- Physical Exam/KAN Be Healthy (most recent)
- Statement of the current diagnosis & 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 educational information to be disclosed consists of (check applicable boxes):

- School Cumulative Records
- Confidential (sensitive) Records
- Special Education Records
- 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 withdrawal of consent. I recognize that health records, once received by the school district, will become education records protected by the Family Educational Right and Privacy Act (FERPA).
 I understand that the records to be used or disclosed pursuant to this authorization may contain:
 1.) records relating to the participation in federally assisted drug and alcohol abuse programs _____
 2.) information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than those notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertain specifically to psychotherapy notes) _____
 3.) information relating to HIV testing, HIV status, or AIDS _____
 I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my signature/initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.
 I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law.
 I acknowledge upon signing this consent that I am waiving my rights under these laws and I am aware of the specific protections afforded or am waving my rights to being informed of the specific provisions of these laws, Statute 42 CFR – Part 2. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations.

PARENT/GUARDIAN: _____
Signature Date

RELATIONSHIP TO STUDENT: _____

STUDENT: (If Applicable*) _____
Signature Date

WITNESS: (Include Title) _____
Signature Date

*Student Age 18 or Older