Port Washington-Saukville School District

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Pupil Name: _____ **Date of Birth:** _____

INSTRUCTIONS: Complete one or both of the Authorization Statements below, place checkmarks by the information that may be disclosed and sign the authorization. In order to allow the exchange of information between the Port Washington-Saukville School District and the identified individual/entity, please check both of the Authorization Statements.

AUTHORIZATION STATEMENTS:

☐ I, the undersigned, hereby authorize the **Port Washington-Saukville School District** to disclose by any means (including written, oral or electronic means) the information indicated below regarding the pupil to:

Name:_____Agency:_____

Address: _____

☐ I, the undersigned, hereby authorize _____, (insert name of individual, organization, or agency) to disclose by any means (including written, oral or electronic means) the information indicated below to the **Port Washington-Saukville School District**.

INFORMATION TO BE DISCLOSED:

Education Information/Records

- ☐ Progress Records
- ☐ Behavioral Records
- ☐ Pupil Physical Health Records
- ☐ Psychological Records
- ☐ Special Education Records
- ☐ Outside Agency Records
- ☐ Law enforcement records

Health Information/Records

- ☐ All Patient Health Information (or specify what records are to be released)
  _____
  _____
  _____
- ☐ Alcohol/Drug Abuse Records

- ☐ Mental Health Records
- ☐ Developmental Disabilities
- ☐ HIV (AIDS) Records

Other Information/Records

- ☐ Other (specify) _____

PURPOSE OF DISCLOSURE: The information is requested for the purpose of educational programming and service, medical evaluation and treatment, health assessment and planning, or other (specify, such as "at request of the individual")_____

ACKNOWLEDGEMENTS:

Receive Records & Authorization - I understand that I have a right to a copy of the records that are disclosed and a right to a copy of this authorization.
Withdrawal of Authorization - I understand that I have the right to revoke this authorization, except to the extent that disclosure has already been made in reliance on this authorization. I understand that my revocation is effective only if it is in writing and it is submitted to the individual/entity that is releasing information.
Re-Disclosure of Health Information - I understand that if my child's health information is released pursuant to this authorization, it may be subject to re-disclosure by a person who receives the health information and may not be protected by federal law.
Voluntary Authorization - I understand that a health care provider may not condition health care treatment, payment or eligibility for health plan benefits of whether or not I sign this authorization.

This permission is valid for one (1) year from the date signed. A copy of this form is as effective as the original. I certify that I am the parent, legal guardian, personal representative of the above named pupil, or that I am the pupil and of majority age, and have authority to sign this release

_____ _____
Signature Date

_____ _____
Print Name Relationship to Pupil
(parent, guardian, personal representative or adult pupil)