

**Kaukauna Area School District**

Educational Services Center  
1701 County CE Kaukauna, WI 54130  
Phone 920-766-6100 Fax 920-759-6104

**Release and/or Exchange of Health and/or Education Information**

I, hereby authorize \_\_\_\_\_  
\_\_\_\_\_ (insert  
school currently attending, agency, health care provider, name and title, address and telephone number) and the  
**Kaukauna Area School District** \_\_\_\_\_  
\_\_\_\_\_ (name(s) of  
school personnel) to release and/or exchange health and education information/records to each other for the  
purposes listed below for the following student.

\_\_\_\_\_  
Student Name (First, Middle and Last)

Grade	Date of Birth	Start Date
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**Description:** The information to be disclosed consists of: \_\_\_\_\_

- Purpose: This information will be used for the following purpose(s):**
- A. Educational Evaluation and Program Planning;
  - B. Health Assessment and Planning for Health Care Services and Treatment in School;
  - C. Medical Evaluation and Treatment;
  - D. Other (specify in detail) \_\_\_\_\_

**Authorization:** This authorization is valid for one (1) calendar year from date of parent/student signature. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release the information. I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose the information have acted in reliance upon this authorization. I understand that I have a right to inspect and copy my information to be used or disclosed, as permitted by applicable law. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25 (2m)(a)(b) and 146.82 – 148.83. I also understand that if I refuse to sign, such refusal will not interfere with mine /my child’s ability to obtain health care.

Parent Signature	Date	Student Signature	Date
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- If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Wisconsin, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for HIV/AIDS, and family planning services.

Copies: Parent or Student\*  
Physician or health care provider releasing the protected health information  
School official requesting/receiving the protected health care information