Kaukauna Area School District
District Registrar
1701 County Road CE, Kaukauna, WI 54130
Phone (920) 766-6100 Fax (920) 766-6104

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

I, hereby authorize

_____
(name of school currently attending, agency, health care provider, name and title, address and telephone number)

and **the Kaukauna Area School District** 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 Name) Date of Birth

_____/_____/_____
Grade School where student will be attending Start Date

Description: The health information to be disclosed of consists of: **All Student Health Records**

Description: The education information to be disclosed of consists of: **Student's Complete Cumulative File and including Behavior File.**

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 Statues 118.25 (2m)(a)(b) and 146.82148.83. 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

* 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