Sheridan School District 48J
AUTHORIZATION TO USE AND/OR DISCLOSE EDUCATIONAL AND PROTECTED HEALTH INFORMATION

1. I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child.

_____ _____
Student/Child's Name Date of Birth

_____ **Sheridan School District 48J**
Other Names Used by Student/Child School or Program Name

Name and address of health care provider/doctor authorized to:
☐ Send/disclose protected health information
☐ Receive/use educational information

_____
_____

Name and address of school authorized to:
☐ Send/disclose educational information
☐ Receive/use protected health information

Sheridan School District 48J
435 S. Bridge St., Sheridan, OR 97378

2. I understand that this information will be used for the following purposes (check all that apply):

☐ Determining eligibility for Special Education or other services	☐ Developing an appropriate Individualized Education Program
☐ Determining student/child's current levels of performance	☐ Other (specify): _____
☐ Developing an individualized health plan	

3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:

☐ Physician's Eligibility Statement	☐ Educational Information	☐ Psychological Evaluations
☐ Health Assessment Statement	☐ IEP document	☐ Social work reports
☐ History and physical exam	☐ Clinic records	☐ Other: _____
☐ Entire medical record	☐ Communicable disease(s)	_____
☐ Prenatal information	☐ Progress notes	

4. By initialing the spaces below, I authorize the use/disclosure of the following information. Specific records requested must be listed below, e.g., assessment, treatment plan, discharge plan.

_____ Drug/alcohol diagnosis, treatment or referral information requested: _____
_____ HIV/AIDS related records requested: _____
_____ Mental health related information requested: _____
_____ Genetic testing information requested: _____

5. I understand that:

a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care.
b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR 164.524)
c. I may revoke this authorization at any time by notifying Sheridan School District 48J in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.
d. Federal policy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.
e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

6. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.

_____
Signature of Parent/Legal Guardian/Student/Child Date Relationship

This authorization expires _____ (month/day/year) (not to exceed one year from date of signature above)