Consent for Exchange of Protected Health Information (PHI)

Student's Name: _____ Date of Birth:_____

Parent/Guardian: _____ Phone:_____

Exchange of health and education information/records between Grand Ledge Public Schools and provider(s) listed below:

Name:_____ Address:_____ Phone:_____

Name:_____ Address:_____ Phone:_____

Name:_____ Address:_____ Phone:_____

Information Requested:

☐ Psycho-Educational Evaluation ☐ Social-Emotional ☐ Physical/Occupational Therapy

☐ Speech, Language, Hearing ☐ I.E.P.C. and I.E.P. ☐ Medical Records/Medical Information

☐ CA60 ☐ Other:_____

Purpose for the Request & Reasons for Disclosure

This information will be used:

1. Educational evaluation and program planning.
2. Health assessment and planning for health care services and treatment in school.
3. Medical evaluation and treatment

School personnel with whom information is to be exchanged :

Teacher(s): _____ _____

_____ _____

_____ _____

School Nurse Consultant:_____ Principal(s):_____

Other: _____ _____

_____ _____

Name of School: _____ Phone Number: _____

Address:_____ Fax number: _____

Exchange can take place via the following methods:

☐ **All of these** ☐ Telephone ☐ Written Correspondence ☐ Fax ☐ E-mails

This authorization is valid for one calendar year. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my care at school.

_____ _____

Parent/Guardian Signature Date