Authorization for the Release of Health and/or Educational Information to GWAEA

Student _____ Birthdate _____ / _____ / _____
Last (legal) First (no nicknames) M.I.

Address: _____ Phone: _____

_____

On behalf of the above named student, I authorize _____
(name of health care provider, agency, or medical institution)

to release evaluation records to Grant Wood AEA (Area Education Agency) and _____ (School or School District)

for the purpose of determining eligibility for and/or provision of appropriate special education and related services.

AEA Contact: _____ District Contact: _____

AEA Address: 4401 Sixth Street SW Cedar Rapids, IA 52404 District Address: _____

For this purpose, I consent to the release of the following health information to the AEA and school district regarding this child from _____ / _____ / _____ to _____ / _____ / _____ : _____ Current Medical Status ____ Current Medications/treatments

_____ Recommendations for School _____ Other _____

I hereby give special permission to the above named medical entity to release records pertaining to: _____ Mental health

_____ Substance abuse/chemical dependence _____ Sexually transmitted disease _____ HIV/AIDS

I understand that the released information becomes a part of the student's educational records as defined by the *Individuals with Disabilities Education Act (IDEA)* and, as such, is protected by the *Family Educational Rights and Privacy Act (FERPA)*. The information may be reviewed by all members of the IEP team and, as appropriate, those identified as having legitimate educational interest. The information may also be used in the future, including if the student moves, for the purpose of Individualized Education Program (IEP) decision making.

I understand that I have the following rights with respect to this authorization:

- The right to inspect or copy the health information to be disclosed by this form.
- The right to receive a copy of this form.
- The right to withdraw this Authorization by written notification at any time (although my withdrawal will not be effective as to uses and/or disclosures already made regarding this form).

This authorization is valid until _____ / _____ / _____ or until one year after the date of signing, whichever occurs first.

_____ _____ _____ / _____ / _____
Signature Relationship to Student Date

Printed Name_____

Health Insurance Portability and Accountability Act (HIPAA)/ Family Educational Rights and Privacy Act (FERPA) Notice

Any and all personally identifiable information regarding children and families receiving Special Education services funded under the *Individuals with Disabilities Education Act (20 U.S.C. ß1400 et seq.)* is protected from unauthorized disclosure under FERPA. Personally identifiable information protected by FERPA is specifically exempted from HIPAA privacy standards. FERPA prohibits disclosure of personally identifiable information without parent consent except in limited circumstances, requires notice to be provided to the child's family regarding their privacy rights, requires providers to keep records of access to a child's records, and contains complaint and appeal procedures which apply to disputes over records in possession of Special Education or its providers, among other provisions. All Special Education providers comply with these procedures.

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Student _____ Birthdate _____ /_____ /_____
Last (legal) First (no nicknames) M.I.

NOTICE TO RECIPIENTS OF MENTAL HEALTH INFORMATION

In accordance with the Iowa Mental Health Information Disclosure Act *(Iowa Code, Chapter 228)*,a recipient of mental health information may redisclose this information only with the written authorization of the subject or the subject's legal representative or as otherwise provided in chapter 228 and 220. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules *(42 CFR Part 2)* restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE TO RECIPIENTS OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed from records whose confidentiality is protected by Federal law. *Iowa Code, Chapter 125* and Federal regulations *(42 CFR, Part 2)* prohibit any further disclosure without the specific written consent of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE TO RECIPIENT OF HIV RELATED TESTING INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. *(Iowa Code 141.23)* Federal confidentiality rules *(42 CFR, Part 2)* restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.