METROPOLITAN SCHOOL DISTRICT OF LAWRENCE TOWNSHIP

HIPAA-Compliant Authorization for Exchange of Health & Educational

Student Name: _____ **Date of Birth:** _____

Address: _____ **Zip Code:** _____

I hereby authorize **Title:** **and**

_____ _____

(insert name of school official or school)

Division of Exceptional Learners, MSDLT-Ivette Stewart **Title:** Data Coordinator, DEL, MSDLT

(insert name of school official or school)

to exchange health and educational information/record for the purpose listed below.

6501 Sunnyside Road, Indianapolis, Indiana 46236 Office: (317)423-8430 Fax: (317)543-3523

(insert address and telephone of school/school district)

(insert address and telephone of school/school district)

Description:

The health information to be shared:

NA

The educational information to be shared:

Information shared may include: student STN transfer to MSDLT; current IEP; current Service Plan; most recent educational evaluation;

Purpose: This information will be used for the following purpose(s):

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

Authorization

This authorization is valid for one school 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 child's ability to obtain health care.

_____ _____

Parent/Guardian/Legal Representative Signature Date

_____

Printed Name

Copies: Parent or student

Physician or other health care provider releasing the protected health information

School official requesting/receiving the protected health information