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) _____

(Other Names Used by Student/Child) _____ (School or Program Name) _____

Name and address of healthcare provider authorized to:
- ❑ Send/disclose protected health information
- ❑ Receive/use educational information

_____
_____
_____

Name and address of school/EI/ECSE program authorized to:
- ❑ Send/disclose educational information
- ❑ Receive/use protected health information

_____
_____
_____

2. **I understand that this Information will be used for the following purposes (check all that apply):**
- ❑ Determining eligibility for Special Education, EI/ECSE, or other services
- ❑ Determining student/child's current levels of performance
- ❑ Developing an individualized health plan
- ❑ Developing an appropriate Individualized Education Program or Individualized Family Service Plan
- ❑ Other (specify): _____

3. **By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:**
- ❑ Physician's Eligibility Statement
- ❑ Health Assessment Statement
- ❑ History and physical exam
- ❑ Entire medical record
- ❑ Prenatal information
- ❑ Educational Information
- ❑ IFSP/IEP document
- ❑ Clinic records
- ❑ Communicable disease{s)
- ❑ Progress notes
- ❑ Psychological evaluations
- ❑ Social work reports
- ❑ Other: _____

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. **By *initialing* the space below, I agree that:**
- ___ The _____ (educational agency) may release educational information about my child to the Oregon Medical Assistance Program (OMAP) to determine eligibility and for Medicaid reimbursement for Medicaid-covered services my child may receive in the educational setting.

6. **I understand that:**
   a. This authorization is voluntary and I may refuse to sign it without affecting my child's healthcare.
   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 _____ 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 privacy 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.

7. **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) _____ (Relationship) _____ (Date) _____

8. This authorization expires on _____ (not to exceed one year from date of signature above).
(Month/Day/Year)

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