WAWASEE COMMUNITY SCHOOL CORPORATION
#1 Warrior Path, Building #2
Syracuse IN 46567

Authorization for Use or Disclosure of Protected Health and Educational Information

I authorize _____,_____
(Name) (Address)
and/or the administrative and clinical staff to disclose the following protected health and/or educational information to:
Attention: _____, Position _____

Wawasee Community School Corporation
#1 Warrior Path, Building #2
Syracuse IN 46567

This authorization permits _____ to disclose the following individually identifiable health or educational information:
_____ Psychoeducational Results _____ Functional Behavioral Analysis _____ Behavioral Intervention Plan
_____ Individual Education Plan and/or Education Plan _____ Discharge Summary/Diagnosis _____ Medication Plan

I understand that the health or educational information being disclosed to _____ may include information relating to a disability. It may also include information about behavioral or mental health service and treatment.

This protected health and educational information is being used or disclosed for the following purposes:
_____ The development of an appropriate educational program.
_____ At the request of the individual.

(NOTE: If requested by me (student) or my Parent/Guardian, the purpose may be listed as "at the request of the individual." The purpose(s) are provided so that I can make an informed decision whether to allow release of the information.) This authorization will expire on the last school day of the current school year.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification of my request to revoke this authorization. I understand that a revocation is not effective to the extent that information has already been released pursuant to this authorization.

I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. However, all educational records are protected by the Federal Education Rights and Privacy Act (FERPA).

I have the right to refuse to sign this authorization unless required by law.

Dated this _____ day of _____, 20 _____.

_____
Signature of Student if 18 yrs. old or Parent/Guardian

_____ _____
Print Name of Student Date of Birth

_____ _____
Print Name of Guardian Description of Legal Guardian's Authority

This authorization complies with HIPAA and Indiana Law.