Whitko Community School Corporation 710 N St. Rd 5, Suite B, Larwill, IN 46764 Ph: 260-327-3677 Fax: 260327-3238

Authorization for Mutual Exchange of Protected Health and Educational Information

RE: _____ D.O.B.: _____
(Student's name)

I authorize Whitko Community Schools and/or the administrative and clinical staff to mutually exchange the following protected health and/or educational information with:

_____
(Hospital, Clinic, Physician, Institution, Association, or School)

_____
(Address of Above)

Name of Contact Person:_____ Phone No: _____

This authorization permits the exchange of the following individually identifiable health or educational information:
☐ General Identifying Data ☐ Individual Education Plan ☐ Psychoeducational Reports ☐ Medical Reports
☐Psychiatric Reports ☐ Functional Behavioral Analysis ☐ Behavioral Intervention Plan
☐Discharge Summary/Diagnosis ☐ Medication Plan ☐ Other (specify):

I understand that the health or educational information being exchanged with Choose an item.
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 exchanged for the following purposes:
☐The development of an appropriate educational program.
☐At the request of:

_____ _____
(Name) (Title)

(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.

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

Date: _____

This authorization complies with HIPAA and Indiana Law.