

**WATERTOWN UNIFIED SCHOOL DISTRICT**  
**HIPAA-Compliant Authorization for Exchange of Information**

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to exchange my/my child's information/records with:

Name: \_\_\_\_\_

School: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

- Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results.
- Medical and/or related records.
- Psychological evaluations or social work reports.
- IEP team evaluations and related reports.
- Appropriate agency reports.
- Individualized education program.
- Other \_\_\_\_\_

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

**Authorization**

This authorization is valid for one calendar year. It will expire on \_\_\_\_\_ [insert date]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25(2m)(a)(b) and 146.82-146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

\_\_\_\_\_  
Parent Signature Date

\_\_\_\_\_  
Student Signature\* Date

\*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Wisconsin, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for HIV/AIDS, and family planning services.

Copies: Parent or student\*  
Physician or other health care provider releasing the protected health information  
School official requesting/receiving the protected health information