DEERFIELD COMMUNITY SCHOOLS
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Pupil Name: _____ **Date of Birth:** _____ **Grade:**_____

INSTRUCTIONS: STEP 1: Complete the *Authorization Statements* section below by placing a check mark by ONE OR BOTH of the statements. In order to allow the exchange of information between the Deerfield Community School District and the identified individual/entity, please check both of the Authorization Statements. **STEP 2:** Complete the *Information To Be Disclosed* section by placing checkmarks by the information that may be disclosed. **STEP 3:** Complete the *Purpose of Disclosure* section by placing checkmarks by the appropriate purpose of disclosure. **STEP 4:** Review the Acknowledgements & Signature section and sign the authorization.

AUTHORIZATION STATEMENTS:

☐ DISCLOSURE BY SCHOOL DISTRICT, I authorize the Deerfield Community School District to disclose by any means (including written, oral or electronic means) the information indicated below regarding the pupil to:

Name:_____ Name:_____
Address:_____ Address:_____
_____ _____
Phone:_____ Phone:_____

☐ DISCLOSURE BY SCHOOL DISTRICT, I authorize _____ (insert name of individual, organization, or agency) to disclose by any means (including written, oral or electronic means) the information indicated below to the Deerfield Community School District.

☐ DEERFIELD ELEMENTARY SCHOOL
340 W. QUARRY STREET
DEERFIELD, WI 53531
(608) 764-5442 Fax: 608-764-8652

☐ DEERFIELD MIDDLE/HIGH SCHOOL
300 SIMONSON BLVD.
DEERFIELD, WI 53531
(608) 764-5431 Fax: (608) 764-5433

INFORMATION TO BE DISCLOSED:

Education Information/Records
- ☐ Progress Records
- ☐ Behavioral Records
- ☐ Pupil Physical Health Records
- ☐ IEP/Evaluation Reports
- ☐ Special Education Records
- ☐ Psychological Records

Health Information/Records
- ☐ Patient Health Information (specify of indicate "all)
  _____
  _____
  _____
  _____
- ☐ Outside Provider Evaluation Report(s)
- ☐ Immunization Record(s)
- ☐ Mental Health Records
- ☐ HIV (AIDS) Records
- ☐ Developmental Disabilities

Other Information/Records:
Other (specify)_____
_____
_____
_____

PURPOSE OF DISCLOSURE:
- ☐ Educational Programming Service
- ☐ Medical Evaluation and Treatment
- ☐ Other _____
- ☐ Health Assessment and Planning
- ☐ Transition Planning

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be used or disclosed– I understand that I have a right to inspect or copy the health information I have authorized to be sued or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department or school.

Right to Receive Copy of this Authorization --- I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to refuse to sign this Authorization --- I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
Right to withdraw this Authorization --- I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department or school. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This permission is valid for one year. A copy of this form is as effective as the original. I certify that I am the parent, legal guardian, personal representative of the above named pupil, or that I am the pupil and of appropriate age, and have authority to sign this authorization.

Signature:_____ Print Name:_____

Relationship to Pupil:_____ Date:_____
(pupil, parent, guardian, or personal relationship)

☐ Check here if you are requesting a copy of education records disclosed by the Deerfield Community Schools (a fee for education record copies may be imposed).