WOOD COUNTY SCHOOLS
FERPA/HIPAA
RELEASE OF INFORMATION

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICAL PROVIDERS AND WOOD COUNTY SCHOOLS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

STUDENT INFORMATION (Please Print): **School** _____ **Grade** _____

_____

Last Name **First Name** **MI** **Date of Birth** **WVEIS Number**

I, the undersigned, do hereby authorize the named agency and/or licensed health care provider(s) to provide health information from the above named student's medical record to and from:

_____

Name/Licensed Health Care Provider/Facility/Agency

_____

Address **City** **State** **Zip Code**

_____ _____

Phone Number **Fax Number**

CHECK ONE

☐ **School Name** _____
School Address _____
_____
Phone Number _____
Fax Number _____

☐ Wood County Schools
Attendance/Home Services
1210 13th Street
Parkersburg WV 26101
Phone 304-420-9663
Fax 304-420-0973

☐ Wood County Schools
Special Education
1210 13th Street
Parkersburg WV 26101
Phone 304-420-9655
Fax 304-420-9689

Consent/Release of Information requested by (Signature) _____

Requested information shall be limited to the following:
- ☐ Phone or fax communication
- ☐ Discharge summary/consultation reports
- ☐ Disease/specific information as described: _____
- ☐ School records (grades, achievement testing, attendance, report cards, discipline records, current IEP, and psychological evaluations)
- ☐ Psychological
- ☐ Other _____

Disclosure of health information is required for the following purpose:
- ☐ Homebound eligibility
- ☐ Medical care
- ☐ Special education evaluation process
- ☐ Individualized Education Program development
- ☐ Other _____

DURATION:
This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for **one year from the date of signature**, if no date entered.

RESTRICTIONS:
Law prohibits Wood County Schools from making further disclosure of health information unless Wood County Schools obtains another authorization or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:
I understand that I have the following rights with respect of this authorization: I may revoke this authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to the agency/Wood County School personnel listed above. My revocation will be effective upon receipt but will not be effective to the extent that Wood County Schools or others have acted in reliance to this authorization.

RE-DISCLOSURE:
I understand that Wood County Schools will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the comprehensive student health file/educational record. The information will be shared with individuals working at or with Wood County Schools for the purpose of providing safe, appropriate, and least restrictive education settings and school health services/programs.

I understand that signing this authorization may be required in order for this student to obtain appropriate services in the educational setting. I have a right to receive a copy of this authorization.

_____ _____ _____
Name (Please Print) Signature Date

_____ _____
Relationship to Student/Patient Phone Number

Original: Comprehensive Student Health File or Student Education File or Special Education Office