Authorization:

This authorization is valid for one calendar year:

Expiration date:
MM/DD/YYYY

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 health records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may become education records protected by the Family Education Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Law (Section 118.125(2m)(a)(b) and 146.81-146.84, Wis. Stats.). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

I am (check one) the person the authorized representative of the person whose information is authorized to be used or disclosed.

Parent/Legal Guardian Signature (if applicable)

Date Signed MM/DD/YYYY:

Student Signature* (if student is 18 years old or older)

Date Signed MM/DD/YYYY:

*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.

This form will be uploaded to our student information system. A copy can be supplied to anyone who has a reason to be informed including the parent/guardian.