LAFAYETTE SCHOOL CORPORATION
AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
AND ACADEMIC RECORDS

Student: _____
DOB:_____Address:_____
_____Phone:_____

1. This authorization for the disclosure of protected health information is given pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the associated regulations which govern the privacy of individually identifiable health information (45 C.F.R. § 164.500 *et seq.*, as amended), and pursuant to applicable Indiana law.

2. You are hereby authorized to disclose and release to the designated agents of Lafayette School Corporation, 2300 Cason Street, Lafayette, IN 47904 the following:

   Records pertaining to_____, as indicated below:

   ____ School health and Immunization Records
   ____ Office visit note(s) ____ Individual Education Plan (I.E.P)
   ____ Active medication(s) ____ Individual Health Plan (I.H.P.)/Action Plan
   ____ Psychological testing ____ Psycho educational evaluations
   ____Therapy note(s) ____ Classroom behavior
   ____ Case Conference Summaries ____ School Achievement Records
   ____ Other: _____

   I understand that the Protected Health Information in _____ medical record may include information relating to Dangerous Communicable Diseases including acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug addiction. **Patient/Legal Guardian Signature _____**

3. The above disclosure is made for the purposes of the treatment of the Student.

4. I understand that Lafayette School Corporation may not require me to sign this authorization as a condition of providing health care treatment for my student. I also understand that this signed consent is required for communication to occur with my student's health care providers.

5. **This authorization shall be valid beginning on _____ and shall expire at the end of current school year or when revoked in writing by parent or guardian.**

6. This request is for written records and oral communication between person(s) designated in the section 2 or their representative and the provider(s): _____
   _____
   _____

7. A photocopy of this authorization shall be valid as the original.

8. Notices:
   a. The individual named below has the right to revoke this authorization by notifying Lafayette School Corporation in writing. After such revocation is delivered to Lafayette School Corporation, no further information will be released pursuant to this Authorization.
   b. The above-named health care provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.

Date: _____

_____
Signature of Patient or Legal Guardian

_____
Printed Name of Patient or Legal Guardian

_____
Relationship to Patient

_____
Address

_____
Phone number (work/home/cell)