



Authorization for the Release of Health and/or Educational Information to GWAEA



Student _____ Birthdate ____ / ____ / ____
Last (legal) First (no nicknames) M.I.

Address: _____ Phone: _____

On behalf of the above named student, I authorize _____
(name of health care provider, agency, or medical institution)

to release evaluation records to Grant Wood AEA and _____
(Area Education Agency) (School or School District)

for the purpose of determining eligibility for and/or provision of appropriate special education and related services.

AEA Contact: _____ District Contact: _____

AEA Address: 4401 Sixth Street SW Cedar Rapids, IA 52404 District Address: _____

For this purpose, I consent to the release of the following health information to the AEA and school district regarding this child from ____ / ____ / ____ to ____ / ____ / ____ :
____ Current Medical Status ____ Current Medications/treatments
____ Recommendations for School ____ Other _____

I hereby give special permission to the above named medical entity to release records pertaining to: ____ Mental health
____ Substance abuse/chemical dependence ____ Sexually transmitted disease ____ HIV/AIDS

I understand that the released information becomes a part of the student's educational records as defined by the *Individuals with Disabilities Education Act (IDEA)* and, as such, is protected by the *Family Educational Rights and Privacy Act (FERPA)*. The information may be reviewed by all members of the IEP team and, as appropriate, those identified as having legitimate educational interest. The information may also be used in the future, including if the student moves, for the purpose of Individualized Education Program (IEP) decision making.

I understand that I have the following rights with respect to this authorization:

- The right to inspect or copy the health information to be disclosed by this form.
- The right to receive a copy of this form.
- The right to withdraw this Authorization by written notification at any time (although my withdrawal will not be effective as to uses and/or disclosures already made regarding this form).

This authorization is valid until ____ / ____ / ____ or until one year after the date of signing, whichever occurs first.

Signature Relationship to Student _____ / ____ / ____
Date

Printed Name _____

Health Insurance Portability and Accountability Act (HIPAA)/ Family Educational Rights and Privacy Act (FERPA) Notice

Any and all personally identifiable information regarding children and families receiving Special Education services funded under the *Individuals with Disabilities Education Act (20 U.S.C. §1400 et seq.)* is protected from unauthorized disclosure under FERPA. Personally identifiable information protected by FERPA is specifically exempted from HIPAA privacy standards. FERPA prohibits disclosure of personally identifiable information without parent consent except in limited circumstances, requires notice to be provided to the child's family regarding their privacy rights, requires providers to keep records of access to a child's records, and contains complaint and appeal procedures which apply to disputes over records in possession of Special Education or its providers, among other provisions. All Special Education providers comply with these procedures.

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