MILWAUKEE PUBLIC SCHOOLS

NAME: _____
LAST FIRST
ADDRESS: _____
SCHOOL: _____
ID: _____ DOB: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

INFORMATION RELEASED TO:

Name: _____
Telephone: _____
Address: _____
State, Zip _____

INFORMATION TO BE RELEASED BY:

Name: _____
Telephone: _____
Address: _____
State, Zip _____

The health information that may be disclosed (including paper, oral, and electronic interchange) under this authorization includes:

- ○ **1.** All protected health information as defined by the federal Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations and patient health care records as defined by Section 146.81 Stats., including information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse.
- ○ **2.** Only the information described below.
  - ○ All psychiatric and psychological reports
  - ○ All social work reports
  - ○ All education testing reports
  - ○ Other: _____

The purpose for this authorization is: (1) at the request of the individual; or (2) : ☐

I understand that if information about me is disclosed to an entity that is not a health care provider or health plan, the information may be redisclosed and no longer protected by the federal privacy regulations. MPS may be subject to other laws and regulations that protect the privacy of the information.

I may refuse to sign this authorization and my refusal to sign will not affect my treatment, payment, enrollment in a health plan or eligibility for benefits. I may revoke this authorization at any time in writing by sending a letter addressed to my providers which specifically revokes this authorization, except to the extent that action has been taken in reliance on this authorization. This authorization expires one (1) year after I am no longer enrolled as a pupil at MPS. A photostatic copy of this authorization shall be as valid as the original.

_____ _____ _____
Signature (Parent/Guardian or Eligible Pupil i.e., Pupil 18 or over) | Relationship to Pupil | Date

_____ _____
Address | Phone Number

Copy of this signed authorization Given: _____ (Signature and Date)

AUTHORIZATION FOR USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

INFORMATION RELEASED TO:

Name: _____
Telephone: _____
Address: _____
State, Zip _____

INFORMATION TO BE RELEASED BY:

Name: _____
Telephone: _____
Address: _____
State, Zip _____

The confidential information that may be disclosed (including paper, oral, and electronic interchange) under this authorization includes: All psychotherapy notes.

The purpose for this authorization is: (1) at the request of the individual; or (2) : ☐

I understand that if information about me is disclosed to an entity that is not a health care provider or health plan, the information may be redisclosed and no longer protected by the federal privacy regulations. MPS may be subject to other laws and regulations that protect the privacy of the information.

I may refuse to sign this authorization and my refusal to sign will not affect my treatment, payment, enrollment in a health plan or eligibility for benefits. I may revoke this authorization at any time in writing by sending a letter addressed to my providers which specifically revokes this authorization, except to the extent that action has been taken in reliance on this authorization. This authorization expires one (1) year after I am no longer enrolled as a pupil at MPS. A photostatic copy of this authorization shall be as valid as the original.

_____ _____ _____
Signature (Parent/Guardian or Eligible Pupil i.e., Pupil 18 or over) | Relationship to Pupil | Date

_____ _____
Address | Phone Number

Copy of this signed authorization Given: _____ (Signature and Date)