Wichita Public Schools
Division of Student Support Services

DEPARTMENT OF HEALTH SERVICES

U.S.D. 259 - Parent Permission to Obtain Information
Authorization for Use and/or Disclosure of Protected Health Information

Student's Legal Name: _____ Date of Birth: _____

1. I hereby authorize U.S.D. 259, its employees, agents, and assigns (collectively, the "District") to use and/or disclose the protected health information identified in paragraph 3, below, as set forth herein.
2. I authorize the following physician(s) and/or agency to disclose the information identified in paragraph 3, below, to the District:

Name(s) of Authorized Person(s) / Agency	***Office Phone***	***Fax Number***
Name(s) of Authorized Person(s) / Agency	***Office Phone***	***Fax Number***
Name(s) of Authorized Person(s) Agency	***Office Phone***	***Fax Number***
Name(s) of Authorized Person(s) / Agency	***Office Phone***	***Fax Number***

3. The information which I am authorizing to be used and/or disclosed is diagnosis(s), current medication(s), course of treatment, prognosis, and/or other information that would be of benefit in determining the most appropriate educational placement.
4. I authorize the information identified in paragraph 3, above, to be used and/or disclosed for the educational evaluation, program planning, and health assessment/planning, for this student to ensure safe health care services and treatment in the school setting.
5. In signing this authorization, I understand and acknowledge the following:
   - ☼ I understand that this authorization is voluntary and that I may refuse to sign it.
   - ☼ I understand that I may revoke this authorization at any time by notifying the District in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization. Any notice of termination must be sent to _____.
   - ☼ I recognize that health records, once received by the school district, will become education records protected by the Family Educational Rights and Privacy Act (FERPA).
   - ☼ I understand this authorization will expire one year from the date listed by the patient/ legal representative signature below.

I, the undersigned, do hereby swear that I am the above-mentioned patient or a legal representative of the above-mentioned patient. I have read and understand the above information and

_____ _____
Signature of Patient / Legal Representative ***Date***

_____ _____
Printed Name of Patient / Legal Representative ***Description of Legal Representative's Relationship to Patient***

ORIGINAL – Student's Health Record **COPY** – Offered to Legal Representative / Student

December 2012