Dubuque COMMUNITY SCHOOLS

Keystone Area Education Agency

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT INFORMATION

STUDENT NAME:	DATE OF BIRTH (MM/DD/YYYY):	PHONE:
ADDRESS:	CITY:	ZIP:

PARENT / GUARDIAN / LEGAL REPRESENTATIVE / STUDENT (over 18, own guardian): Your signature on this *Authorization for Exchange of Confidential Information* will give the individual, program, organization or entity listed permission to disclose and/or exchange the confidential information indicated below.

I authorize Dubuque Community School District/Keystone AEA to exchange confidential information with:

ADDRESS:	CITY:	ZIP:

THE PURPOSE FOR THE EXCHANGE OF INFORMATION IS FOR:

[ ] COORDINATION AND CONTINUITY OF CARE, EVALUATION [ ] INSTRUCTION AND EDUCATIONAL PLANNING [ ] OTHER

If other, please specify:

YOUR SIGNATURE WILL GIVE PERMISSION FOR THE FOLLOWING SPECIFIC INFORMATION TO BE EXCHANGED:

[ ] MEDICAL STATUS [ ] CURRENT MEDICATIONS/TREATMENTS [ ] RECOMMENDATIONS FOR SCHOOL [ ] OTHER

If other, please specify:

Before giving your permission for exchange of confidential information, please carefully review the following:

This authorization is good until the following date: ___/___/___ ; or until one year after the date of signing, whichever occurs first. I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain services. I also understand that if I revoke, the revocation will take effect on the day it is received in writing. All members of the Dubuque Community School District and Keystone AEA staff that are identified as having a legitimate educational interest may review the information received. The information may also be used in the future, including if the student moves, for the purpose of educational decision making.

Health Insurance Portability and Accountability Act (HIPAA)/Family Educational Rights and Privacy Act (FERPA) Notice. Any and all personally identifiable student information 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 student's records, and contains complaint and appeal procedures which apply to disputes over records, including records in possession of special education or its providers, among other provisions.

I further understand that, **except** in the case of substance abuse, mental health or AIDS-related information, if the individual, program, organization or entity that receives the information requested is not covered by the federal privacy regulations or is not a business associate of these entities, the information described above may be re-disclosed and will no longer be protected by the regulations.

Iowa and/or Federal law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization.

I SPECIFICALLY AUTHORIZE AND CONSENT TO THE DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.

_____ _____ _____

SIGNATURE DATE RELATIONSHIP TO STUDENT

_____

WITNESS SIGNATURE

» PLEASE COMPLETE BOTH SIDES

NOTE: If you wish to save data typed into this form, first save the file on your computer and re-open from your computer prior to typing.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE, OR AIDS-RELATED INFORMATION

I acknowledge that information to be released to the individual, program, organization or entity listed above (Iowa Code Chapters 228 and 125, Iowa Code 141.23 and Federal regulations 42 CFR, Part 2) may include material that is protected by Federal and/or State Laws applicable to substance abuse, mental health, and/or AIDS-related information. Additionally, I understand that I have the right to inspect or copy the health information to be disclosed by this form and the right to receive a copy of this form.

I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO:

Check YES or NO for each item:

[ ] YES [ ] NO Substance Abuse (drug or alcohol) information

[ ] YES [ ] NO Mental Health Information

[ ] YES [ ] NO AIDS-related information, diagnosis and test results

SIGNATURE	DATE	RELATIONSHIP TO STUDENT

WITNESS SIGNATURE

Furthermore, I **SPECIFICALLY AUTHORIZE** disclosure and re-disclosure of this confidential information to all of the persons referred to above. In order for the above information to be released, you must sign here and at the bottom of page 1 of this form.

If mental health information is being disclosed, I acknowledge receipt of a copy of this Authorization.

SIGNATURE	DATE	RELATIONSHIP TO STUDENT

WITNESS SIGNATURE

Federal and/or State law specifically require that any disclosure or re-disclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Chapter 228 and Chapter 141(A) of the Iowa Code and other applicable laws.

NOTE: A PHOTOCOPY OR EXACT REPRODUCTION OF THIS SIGNED AUTHORIZATION SHALL HAVE THE SAME FORCE AND EFFECT AS THE ORIGINAL.