SEK INTERLOCAL # 637
400 N Pine
Pittsburg, Ks 66762
Phone 620-235-3180 Fax 620-235-3184

AUTHORIZATION TO DISCLOSE INFORMATION, INCLUDING CHILD'S INDIVIDUALLY PROTECTED EDUCATION AND HEALTH INFORMATION

(Pursuant to HIPAA Privacy Regulation, 45 C.F.R. ~164.508)

A. AUTHORIZATIONS: INFORMATION COVERED; PERSONS AUTHORIZED TO MAKE AND TO RECEIVE DISCLOSURES; PURPOSES OF DISCLOSURES; MIMINUM NECESSARY INFORMATION; METHOD OF DISCLOSURES.

I,_____, am the (choose correct one)_____parent

_____ legal guardian of the following minor child with authority to act on their behalf:

Child's Full Name:_____ Date of Birth:_____

On behalf of the minor child named above, I hereby authorize _____:
Agency name

And their employees, contractors, and agents:

- **To disclose protected educational and/or health information about my child.** (choose those that apply)

__ Progress Note **__ Correspondence**
__ Physical Exams **__ Immunizations**
__ Procedure Reports **__ Psychotherapy Notes**
__ IEP **__ Psychology Reports**
__ Initial/Re-evaluations **__ Functional Assessments**
__ Behavioral Intervention Plan **__ Health Care Plan**
__ Other items_____

_____

- **To the SEK Interlocal #637, that is providing educational services to my child, and their employees.**
- **For the limited purpose of providing help in planning for my child's needs both emotionally and physically in their educational setting.**

I also authorize the disclosing organization designated above and their employees, contractors, and agents:

(1) To make those authorized disclosures in any manner, including, but not limited to orally, in paper documents, or electronically by e-mail, fax machine.
(2) To disclose only the minimum information necessary to enable The_____ organization to provide needed services to my child.

B. LIMITATIONS AND CONDITIONS ON MY AUTHORIZATIONS.

The disclosures of my child's information that I am authorizing are subject to these limitations and conditions.

(1) No organization or person may make a disclosure if they have any reason to believe that recipient of the information will use any or all of the information for an unauthorized purpose.
(2) I make no other limitations or conditions on the disclosures I have authorized.

C. I understand that the record to be used or disclosed pursuant to the authorization may contain:

1) ***information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than those notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately.***
(unless this authorization pertains specifically to psychotherapy notes)

2) ***information relating to HIV testing, HIV status, or AIDS I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my signature/ initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.***

D. RE-DISCLOSURES OF INFORMATION BY AUTHORIZED RECIPIENTS.
Understand that my child's information will be disclosed to educational institutions that are required by Federal law (**Family Educational Rights and Privacy Act, 20 U.S.C. 1232g**) to maintain the confidentiality of that information. I also understand that the organization and persons that I have authorized to disclose my child's information have no information that those institutions may make. Any re-disclosures of my child's information by the institutions are subject to my control and to the applicable Federal law.

E. CONSEQUENCES OF NOT SIGNING AUTHORIZATON.
I understand that if I do not authorize disclosures of my child's information by signing this Authorization, the _____ may be hampered in providing appropriate services to my child.

F. **EFFECTIVE DATE OF THIS AUTHORIZATON.**
This Authorization to disclose my child's information to the _____is effective the day I sign this Authorization.

G. EXPIRATION OF THIS AUTHORIZATION.
This Authorization to disclose my child's information to the _____expires on which ever date occurs first:

1) The date on which I deliver my written revocation of this Authorization the that I authorized in Section A, above, to make discloser.
2) One year from today's date.

E. RIGHT TO REVOKE MY AUTHORIZATION.
I specifically reserve the right to revoke this authorization at any time. I understand that, for my revocation to be effective, I must revoke this Authorization in writing and deliver that written revocation or cause it to be delivered to the correct address for the organization that I authorized to disclose information._____
Organization address

I understand that **SEK Interlocal #637** , their employees, contractors, and agents are authorized to continue disclosing information about my child to _____until my written revocation of this Authorization is delivered to them.

My Name (please print) **_____**

My Signature _____ Date _____

Authorization Received by _____ Date _____