Helping Schools
ICISD
Ionia County Intermediate School District
Help Students

Authorization to Disclose Information

Student: _____ Date of Birth: _____

I understand that services provided to my child may come from different agencies. In order to plan for and provide the best possible care for my child and our family, various professionals may need to share information about my child. This form is an authorization, or permission from me, for those professionals to share the information I would like shared. I understand that this information may be used to help decide if my child is eligible for services, how best to coordinate and provide those services, and the services for which we qualify.

The agencies and persons I have initialed below have my permission to share the information about my child and family that I have listed. This could be electronic, verbal, or written. I understand that information will NOT be shared without my authorization with anyone who does not have a valid reason for it or unless authorized under applicable federal and state laws. I understand that this information will not be shared with anyone who has not agreed to meet applicable confidentiality standards. I am aware that I can, without penalty, at any time, cancel this consent and not share information with these persons or agencies. My authorization to share information is voluntary and is good for 12 months. At any time I may, in writing, cancel this authorization to share information form.

Agencies Authorized to Exchange Information *(initial those that apply)*

Info Codes	Initial	Agency/Person	Info Codes	Initial	Agency/Person
		Ionia County Intermediate School District (ICISD)			Physician Name/Address:
		ICISD Local Education Agencies/Districts			Physician Name/Address:
		The Right Door for Hope, Recovery, & Wellness (CMH)			Physician Name/Address:
		Michigan Commission for the Blind			Other:
		Michigan Rehabilitation Services			Other:
		Ionia County Dept. of Human Services (DHS)			Other:
		Hospital:			Other:
		Other:			Other:
		Other:			Other:

Information Codes

1-Educational Records, including any IEPs of/from ICISD and/or LEA
2-Speech Therapy Reports
3-Occupational Therapy Reports & Prescriptions
4-Physical Therapy Reports & Prescriptions
5-Medical Reports
6-Psychological Reports
7-Initial assessment/evaluation report
8-Progress Reports
9-Discharge summary
10-Social/Developmental histories/reports
11-Vocational Summaries/reports
12-Coordination of Services
13-Medicaid Number (This will be used to access information associated with the number that is needed to ensure diagnosis, treatment, & payment of services.)
14-Other: _____
_____
15-Prescription for: _____
16-All Information.

Consent for Authorization to Disclose Information *(Initial one of the two statements.)*

___ My signature below is my consent and agreement to the following:

- I have read and understand this consent form (or it has been read to me in a language I understand).
- I understand that my authorization or consent to allow the sharing of information about my child is voluntary and I may deny or revoke consent at any time, without penalty. Revocation of consent is not retroactive.
- I understand that information about my child will also be kept on a database that is subject to the same confidentiality provisions.
- I understand the confidentiality of information about my child is protected by state and federal law, including the Individuals with Disabilities Education Act (IDEA), the Family Educational Rights and Privacy Act (FERPA), and the Health Insurance Portability and Accountability Act (HIPAA). The protected health information (PHI) or personally-identifiable information (PII) in my child's records cannot be disclosed, given, sold, or transferred in any way to any other agency/program (and its contractors or authorized representatives) not specified in this release unless otherwise specifically authorized by federal or state laws.
- I understand that authorizing the disclosure of health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or services, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.
- I authorize the agencies designated and their representatives to engage in verbal or written communication in order to share records and information as indicated above.

___ My signature below indicates that I do NOT authorize any information to be shared at this time:

_____ _____ _____
Signature of Student or Parent/Guardian *Initials* *Date Signed*

Authorization Obtained By:

_____ _____
Witness *Date Signed*

To Renew Authorization

If authorization changes, complete a new form. If authorization remains the same (both in terms or person authorizing and content), initial and sign below:

____ I renew my authorization date _____. This authorization will remain in effect until _____ or until revoked in writing.

_____ _____ _____
Signature of Student or Parent/Guardian *Initials* *Date Signed*

To Withdraw Consent *(Initial and sign below)*

____ I withdraw my consent for personnel/agencies to share information as listed on the *Authorization to Share Information* form dated _____.

_____ _____ _____
Signature of Student or Parent/Guardian *Initials* *Date Signed*