AUTHORIZATION TO USE AND/OR DISCLOSE
PROTECTED HEALTH AND EDUCATIONAL INFORMATION

INDIANAPOLIS PUBLIC SCHOOLS
Special Education / Student Services Department

Student Name: _____

Address: _____

Telephone: _____ DOB: _____

☐ I hereby request and authorize _____
(Agency, School, Hospital, Doctor, etc.)

_____
(Street Address, City, State, Zip) (Telephone Number) (Fax Number)

to furnish to _____ Indianapolis, IN 462
(Name of School / Department in IPS) (Street Address, City, State, Zip)

Attention _____ Telephone No._____ Fax No. _____
(Name of IPS Person / Position)

any and all pertinent information, including verbal communication and/or any of the following reports:

____Attendance Reports
____Birth Certificate
____Case Conference Reports / IEPs
____Discharge Reports
____Discipline Reports
____Grade Reports / Testing Results
____Hearing Evaluation / Vision Evaluation
____Immunizations
_____Medical File
_____Multidisciplinary Evaluation Team Reports
_____OT Evaluation / Progress Reports
_____Psychological Evaluation Reports
_____PT Evaluation / Progress Reports
_____Speech/Language Evaluation / Progress Reports
_____Others_____
_____

☐ I hereby request and authorize Indianapolis Public Schools to verbally communicate with and/or furnish any or all of the above-marked files to _____
(Name / Position) (Agency, School, Hospital, Doctor, etc.)

_____
(Street Address, City, State, Zip) (Telephone Number) (Fax Number)

This information will be used to develop an education program for the above-named student. This authorization may be revoked at any time by the undersigned by giving written notice to _____.
(Name of IPS Person / Position)

Revocation of this authorization will <u>not</u> affect any action taken in reliance on this authorization before IPS' receipt of the notice of revocation. By authorizing the disclosure of the student's health information in accordance with this Authorization, the student's health information may be further disclosed and may no longer be protected by federal health information privacy laws.

This authorization will expire (complete one):
☐ On _____/_____/_____
☐ On occurrence of the following event: _____
_____
☐ At expiration of the 20___ - 20___ school year

_____
(Signature of Parent / Guardian)

_____ Date: _____
(Printed)