



The Arrowhead Union High School District

South Campus/District Office
700 North Avenue
Hartland, Wisconsin 53029
(262) 369-3611

North Campus
800 North Avenue
Hartland, Wisconsin 53029
(262) 369-3612

<http://www.arrowheadschoools.org>

Student/Patient Name: _____ DOB: _____

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I (we), the undersigned, hereby request and authorize:

Telephone (____) _____
Fax (____) _____

To exchange with:

Michelle Altenberger, School Psychologist
Arrowhead Union High School
700 North Avenue
Hartland, WI 53029
Telephone (262) 369-3611 ext. 4117
Fax (262) 367-2014

The confidential information that may be disclosed (including paper, oral, and electronic interchange) under this authorization includes:

- _____ 1. All education records as defined in the federal Family Educational Rights and Privacy Act (FERPA) and pupil records as defined in Section 118.125, Stats.
- _____ 2. Only the information described below:
 - _____ All psychiatric and psychological reports
 - _____ All social work reports
 - _____ All education testing reports
 - _____ Other: _____

The purpose for this authorization is: (1) at the request of the individual; or (2) _____

This authorization expires one (1) year after I am no longer enrolled as a pupil at AHS. I may revoke this authorization at any time in writing by sending a letter addressed to the individual or entity authorized by this form to disclose confidential information which specifically revokes this authorization, except to the extent that action has been taken in reliance on this authorization. If disclosure authorized by this form is to be made by AHS, notice of revocation should be made to Arrowhead Union High School. A Photostatic copy of this authorization shall be as valid as the original.

Signature (Parent/Guardian or Eligible Pupil (i.e., 18 or over) _____

Relationship to Pupil _____

Date _____

District Office Fax (262) 367-7406
South Campus Office Fax (262) 367-4693. North Campus Office Fax
(262) 369-0996

Student/Patient Name: _____ DOB: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I (we), the undersigned, hereby request and authorize:	To exchange with:
Michelle Altenberger, School Psychologist Arrowhead Union High School 700 North Avenue Hartland, WI 53029 Telephone (262) 369-3611 ext. 4117 Fax (262) 367-2014	_____ _____ _____ Telephone (____) _____ Fax (____) _____

The health information that may be disclosed (including paper, oral, and electronic interchange) under this authorization includes:

_____ 1. All protected health information as defined by the federal Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations and patient health care records as defined by Section 146.81 Stats., including information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ 2. Only the information described below:

- _____ All psychiatric and psychological reports
- _____ All social work reports
- _____ All education testing reports
- _____ Other: _____

The purpose for this authorization is: (1) at the request of the individual; or (2) _____

I understand that if information about me is disclosed to an entity that is not a health care provider or health plan, the information may be redisclosed and no longer protected by the federal privacy regulations. AHS may be subject to other laws and regulations that protect the privacy of the information.

I may refuse to sign this authorization and my refusal to sign will not affect my treatment, payment, enrollment in a health plan or eligibility for benefits. I may revoke this authorization at any time in writing by sending a letter addressed to my providers which specifically revokes this authorization, except to the extent that action has been taken in reliance on this authorization. This authorization expires one (1) year after I am no longer enrolled as a pupil at AHS. A photostatic copy of this authorization shall be as valid as the original.

Signature (Parent/Guardian or Eligible Pupil (i.e., 18 or over))

Relationship to Pupil

Date

Address

Phone Number

Copy of this signed authorization given: _____ (Signature and Date)

AUTHORIZATION FOR USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

The confidential information that may be disclosed (including paper, oral, and electronic interchange) under this authorization includes: All psychotherapy notes.

The purpose for this authorization is: (1) at the request of the individual; or (2): _____

I understand that if information about me is disclosed to an entity that is not a health care provider or health plan, the information may be redisclosed and no longer protected by the federal privacy regulations. AHS may be subject to other laws and regulations that protect the privacy of the information.

I may refuse to sign this authorization and my refusal to sign will not affect my treatment, payment, enrollment in a health plan or eligibility for benefits. I may revoke this authorization at any time in writing by sending a letter addressed to my providers which specifically revokes this authorization, except to the extent that action has been taken in reliance on this authorization. This authorization expires one (1) year after I am no longer enrolled as a pupil at AHS. A photostatic copy of this authorization shall be as valid as the original.

Signature (Parent/Guardian or Eligible Pupil (i.e., 18 or over))

Relationship to Pupil

Date