**PERMISSION FOR COLLABORATION FOR YOUR CHILD’S HEALTH**

**HEALTH CARE PROVIDER & HEALTH PLAN**

Family Educational Rights and Privacy Act

*What is FERPA?*

The Family Educational Rights and Privacy Act (FERPA) is a Federal law that protects the privacy of student education records. Generally, schools must have written permission from the parent, or student if over 18, in order to release any information from a student's education record.

*Permission for what?*

The [DISTRICT NAME] is requesting your consent because we may need to share information contained in our student records with your child’s Health Care Provider and Health Plan. Health Care Providers are the physician(s) or nurse practitioner(s) who take care of your child, as noted in the district’s records. A Health Plan is an organization that administers your child’s health care benefits, such as Medicaid or a health insurance company.

*Why is this important?*

This consent form allows the district, when requested or necessary, to assist with coordination of health care, including benefits, by sharing health information from the student’s education record. Without your consent, the district is limited in how it can collaborate with the Health Care Provider or Health Plan to help you or your child.

*What this form* ***does not*** *do.*

* This form only authorizes the district to disclose information. Each Health Care Provider or Health Plan may have its own way of getting permission from you for them to share information with the district.
* Your signature **does not** authorize the district to obtain medical treatment for your child on your behalf.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please help us link you and your child to health services by signing and returning this form.*

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**NAME OF STUDENTS(S)**

Name of student(s) whose records will be shared with Health Care Providers and Health Plans:

|  |
| --- |
|  |

**ADDRESS OF STUDENT(S)**

Places where the student(s) live:

|  |
| --- |
|  [ ] check here if you allow the district to provide any current address available in the district’s records |

**CONTACT INFORMATION**

Your phone or email that a Health Care Provider or Health Plan can contact you:

|  |
| --- |
| [ ] check here if you allow the district to provide any current contact information available in the district’s records |

**WHAT IS DISCLOSED AND WHY**

I consent to the disclosure of all health record information maintained by the district for student(s) listed above which are necessary so:

> Health Care Providers and the district can coordinate medical care.

> Health Plans can contact me to assist with getting medical care and support services for which my child is eligible, such as appointments with medical professionals, transportation, lower fees, and special health management programs.

I understand that I am entitled to receive a copy of any disclosed records. If you wish to receive a copy please provide an email or street address where the records should be sent.

I understand Health Care Providers or Health Plans may further use records provided by the district for contacting me or verifying information.

This consent is valid until revoked by the parent or eligible student.

Signature of Parent or Eligible Student Date

|  |
| --- |
| This consent is provided for in the Family Educational Rights and Privacy Act of 1974, 34 C.F.R.  99.30. |