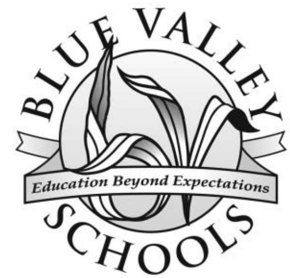
18-21 PROGRAM
Blue Valley School District



Dear Parents,

Listed on the enrollment section of our website, you will find a form titled "Authorization to Disclose and/or Receive Health/Education Information." In the past we have found this to be a confusing from, so we wanted to provide some specific direction.

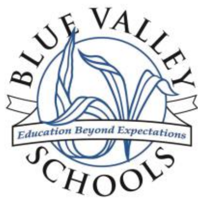
The intent of this form is to provide the school district with prior authorization to discuss health and educational issues with outside service providers. These may include doctors, therapists or adult case managers who work with your student outside of the 18-21 Program. Often these providers will be asked by families to contact us directly to either observe the student or to provide information. Additionally, we may ask the families if we can directly contact a service provider to coordinate transition and educational activities. We are unable to do either without this signed consent.

Therefore, on the "Authorization to Disclose and/or Receive Health/Education Information," please list any adult case managers, doctors or therapists you would like us to collaborate with on both sections "A" and "B". You do not need to list all service providers your student sees, only those who will be instrumental in ensuring the success of your student both while at Blue Valley and as they begin to transition to their post-secondary plans. This will allow us to talk to outside providers if they call us directly for information. If your student does not have any outside service providers assisting with their transition, simply mark "N/A" in both sections "A" and "B".

Thank you,

18-21 Certified Staff

Blue Valley 18-21 Program 7500 West 149th Terrace Overland Park, KS 66223
Phone: 913-239-7900 Fax: 913-239-4588



Blue Valley School District (BVSD)
Educational Services
15020 Metcalf, Overland Park, KS 66283
Phone: 913-239-4057

AUTHORIZATION TO DISCLOSE AND/OR RECEIVE HEALTH/EDUCATION INFORMATION

Student ____________________ DOB ______________ Student ID No. ______________

Address ________________________ City, State, Zip ________________________

School 18-21 Program Grade AC Medical Record No. (if available) ______________

A. **Organization Name and the Person(s) DISCLOSING the Information (specifically identify):**
Blue Valley 18-21 Program /________________________________

B. **Organization Name and the Person(s) RECEIVING the Information (specifically identify):**
Blue Valley 18-21 Program /________________________________

C. **Information to Be Disclosed:** I authorize the disclosure of any information about the diagnosis of and/or the services provided to the above-referenced student for the service dates of 08/1/2017___________ to 6/1/2018____. The following information can also be disclosed: Information relative to school/transition/behavior programming

D. **Information is Being Disclosed for the Following Purpose(s): School programming and/or Behavior/Transition Planning**

Under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996, I understand that::

1. I am not required to sign this authorization and I can refuse to sign it.
2. In general, just because I refuse to sign this authorization, the Person(s) named in Section A above cannot refuse services to the student.
3. The information disclosed may also be disclosed to others. The information cannot be disclosed to others if the person or agency who receives this information is also required to follow privacy rules.
4. The law allows the Blue Valley School District to use and disclose this information without obtaining your permission for the purposes of providing appropriate services, and to enable the district to receive funds from other agencies which assist in paying for those services.
5. I may review, or in specific circumstances receive a copy of, the information requested in this authorization.
6. I can withdraw this authorization at any time. I must do so in writing and give it to the Provider named in Section A above. If I withdraw this authorization, any information disclosed prior to my withdrawal will not be affected.

This authorization expires one year from the date I signed it, unless I withdraw it earlier.

Signature of Patient/Student (or Patient/Student Representative) ____________________ Date ______________

Printed Name of Patient/Student (or Patient/Student Representative) ____________________ Relationship to Patient/Student ______________

DO NOT WRITE BELOW THIS LINE – For Blue Valley School District Use Only

Date Request Sent		By Whom	
Records Received		Date	

Copies: White- BVSD School; Yellow- BVSD Education File; Pink- Other Person(s)/Organization; Gold- Individual Granting Authorization