NORTH FOND DU LAC SCHOOL DISTRICT
School Health Programs

Early Learning: 920-929-3762/fax 920-322-9117
Friendship Learning 920-929-3757/fax 920-929-7020
Bessie Allen: 920-929-3754/fax 920-929-3747
Horace Mann: 920-929-3740/fax 920-929-3664

May, 2020

RE: RELEASE OF INFORMATION FOR ATHLETICS 2020-21 SCHOOL YEAR

Attached is a release of information for your child's primary physician. If they sustain a concussion during their sports, we would have the ability to work with their doctor to make accomodations for academics, if needed, as long as we have this form on file. It will also help us to communicate between school, the doctors, and home more effectively. Our goal is to work with the doctors and families to get all students back to both academics and sports as soon as possible, as long as they are cleared from any head injury.

There is both a front and back release of information. You only need to complete **one** of them. If you have an Aurora physician, they require the Aurora release of information to be completed. Any other Healthcare facility will accept our District's release of information.

Please complete one of the sides, sign it and return with all other paperwork.

If you have any questions or concerns, please reach out to either myself or Nurse Voss. We are here to help!

Bridgett Amadon, BSN, RN
Emily Voss, LPN
School Nurses for Bessie Allen and Horace Mann
North Fond du Lac School District
(920) 929-3740 ext. 5158 (High School)
(920) 929-3654 ext 4116 (Middle School)

Permission to Obtain and Release Information

North Fond du Lac School District
325 McKinley St North Fond du Lac, WI 54937

Student Information

This form provides authorization to release and/or obtain educational records and information relating to:

Student Name: ______________________ Date of Birth: ___/___/___

Address: ______________________ Phone Number: ______________

City: ______________ State: ______ Zip Code: __________

Individual/Agency Information

I, the undersigned, give my permission to:

Name(s) of School Personnel Requesting Information: Bridgett Amadon RN, Emily Voss LPN

Emails of School Personnel Requesting Information: bamadon@nfdlschools.org Evoss@nfdlschools.org

School Name: Horace Mann High School

School Address: 325 Mckinley St. No. Fonddulac Wi 54937

School Phone Number: 920-920-3740 ext 5158 School Fax Number: 920-929-3745

to obtain/release information from/to:

Name: ______________ Agency: ______________

Phone Number: ______________ Fax Number: ______________

Address: ______________________________

City: ______________ State: ______ Zip Code: __________

Description of Educational Records Requested and/or To Be Disclosed:

- ☐ Academic records/Transcripts of credits and grades
- ☒ Medical/Health/~~Behavioral Health~~ records
- ☐ Psychological evaluations or social work reports
- ☐ Individualized Education Program (IEP) team evaluations and related reports
- ☐ Individual Education Program (IEP)
- ☐ Appropriate agency reports
- ☐ Discipline records and expulsion proceedings
- ☒ Verbal Communication
- ☒ Medical history/diagnostic/therapeutic information
- ☐ Other (please specify): ______________

Purpose of Authorization

This information is being requested for the purpose of: Concussion sustained during Sports

Expiration and Revocation

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. If not revoked, this authorization will expire one year after the date on which the authorization is signed.I recognize that health records, once received by the school district, may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Education Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statutes 118.25 (2m) (a) (b) and 146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

______________________________ ______________

Signature of parent/guardian Date

The school district does not discriminate on the basis of race, sex, religion, disability, or national origin.

Aurora Health Care® Milwaukee, Wisconsin

MRN / Chart #: ____________

1) PATIENT INFORMATION:

Name | Address | City | State | Zip

Date of Birth | ( ) Daytime Phone | Previous Name

2) AUTHORIZES: Aurora Health Care – Provider: ____________

Name of Health Care Provider / Plan / Other

Address

3) TO DISCLOSE TO: ☐ Self, Delivery Options: ☐ Pick up ☐ View on Site ☐ Mail to address above ☐ Electronic Format: ______

☐ To be picked up by, I hereby authorize ____________ to pick up my records. (Photo ID required.)

☒ Send to: School Nurse-NFDL School District: B.Amadon, RN, J. Shafer LPN, E. Voss, LPN

Name of Health Care Provider / Plan / Other

305 McKinley Street, North Fond du Lac, WI 54937 Or ____________

Address | Health Care Provider FAX #

Recipient (Contact) Phone Number: (920) 929-3754

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From ______ (month/year) to ______ (month/year) If left blank, only information from the past two (2) years will be disclosed.

5) INFORMATION TO BE DISCLOSED: ☒ Verbal ☒ Written

☐ Billing Records related to (specify): ____________
☐ Emergency Department Reports
☐ Hospital Summary – *a general abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports & ER.*
☐ Imaging Films (X-ray)
☐ Imaging Results
☐ Immunizations
☐ Lab Reports
☒ Procedure Op Reports
☒ Progress Notes/Updates
☒ Other: Verbal communication

I understand that the information to be disclosed may include information regarding genetic testing, and mental illness, alcohol/drug abuse, HIV Test results, AIDS/AIDS related illness, and developmental disabilities. We will disclose such information, unless you indicate below that you do not want such information disclosed:

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities ☐ Genetic Testing

6) EXPIRATION: This Authorization is good until the following date / event: ____________
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) PURPOSE (Check all that apply - **copy fees may apply**)
☐ Further Medical Care – no fee ☐ Insurance Eligibility/Benefits – fee $ ☐ Legal Investigation /Action – fee $
☐ Personal (at my request) - possible fee $ ☐ Forms Completion - possible fee $ ☒ Other: School Nurse / School Health (specify)

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) SIGNATURE OF PATIENT / LEGAL REP: ____________ DATE: ______

If signed by a person other than the patient, complete the following:
1. Individual is: ☒ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin / executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only: Signature/ID verified ☐ Yes ☐ No Completed by: ____________ (Name / Date) # of pages released ____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
(HIM/ROI Authorization)

White – Medical Record
Yellow – Patient
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