



**HIPAA/FERPA –Authorization for Exchange of Education & Health Information**

**Patient/Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I hereby authorize:

(Insert health care provider: **name, title, address, & telephone**)

and **Attn: Academic Advisor, Schiller International University**, to exchange health and education information/records for the purpose listed below.

**Description:**

**Authorization for phone and email communication or written reports related to:**

**Disclosure or the following health and/or agency information:**

1. Disability diagnosis
2. History of the student’s disability and previous accommodations
3. Effect of the student’s disability on the student’s performance of activities within his or her educational program.
4. Current needs in an educational and career setting in relation to the student’s disability
5. Appropriate agency reports

**Disclosure of the following educational information:**

1. Student’s program, attendance, academic assessment, and progress Schiller International University
2. IEP/Section 504 Team evaluations, IEP/Section 504 plans, and related reports from K-12 schools

**This information will be used for the following purpose(s):**

1. Assessment and approval of appropriate disability related educational accommodations.
2. Other: \_\_\_\_\_

**Authorization**

This authorization is valid for one calendar year. It will expire on \_\_\_\_\_ (insert date). 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. I recognize that health records, once received by the college, may not be protected by the HIPAA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA).

\_\_\_\_\_  
Student Signature Date

\_\_\_\_\_  
Parent Signature\* Date

\*Required if student is a minor.