JEFFERSON COUNTY SCHOOL DISTRICT 509J

PRIOR NOTICE and PARENT/GUARDIAN CONCSENT TO EVALUATE UNDER SECTION 504

Date:

To:

From: Counselor

This letter is to provide you notice that Jefferson County School District 509J proposes to evaluate _____ and determine if he/she is eligible for services under Section 504 of the Rehabilitation Act of 1973.

The 504 Team at Madras High School has concluded that the following assessments are necessary to determine if your child has a disability under Section 504 and needs a 504 Plan:

Your written consent is necessary because this is a(n):

_____ Initial Evaluation
_____ Personality Testing (including behavior checklists)
_____ Individual Intelligence Test
_____ Other:

You will be invited to participate in a meeting to review the evaluation results and to determine if your child is eligible for a plan under Section 504.

PARENT/GUARDIAN CONSENT

I understand that the granting of consent for evaluation is voluntary.

_____ Consent to evaluate is given

_____ Consent to evaluate is denied

_____ _____
Parent's/Guardian's Signature Date

If you have questions, please contact me. Thank you for working with us to provide appropriate services for your child.

Enclosure: Section 504 *Notice of Parent/Guardian and Student Rights in Identification, Evaluation and Placement*

295 S.E. Buff Street, Madras, Oregon 97741

Authorization to Use and/or Disclose Educational and Protected Health Information

1. I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child.

(Student/Child's Name) _____ (Date of Birth) _____

(Other Names Used by Student/Child) _____ (School or Program Name) _____

Name and address of health care provider authorized to:
- ☐ Send/disclose protected health information
- ☐ Receive/use educational information

Name and address of school/EI/ECSE program authorized to:
- ☐ Send/disclose educational information
- ☐ Receive/use protected health information

2. I understand that this information will be used for the following purposes (check all that apply):

- ☐ Determining eligibility for Special Education, EI/ECSE, or other services
- ☐ Determining student/child's current levels of performance
- ☐ Developing an individualized health plan
- ☐ Developing an appropriate Individualized Education Program or Individualized Family Service Plan
- ☐ Other (specify): _____

3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:

☐ Physician's Eligibility Statement	☐ Educational Information	☐ Psychological evaluations
☐ Health Assessment Statement	☐ IFSP/IEP document	☐ Social work reports
☐ History and physical exam	☐ Clinic records	☐ Other: _____
☐ Entire medical record	☐ Communicable disease(s)	_____
☐ Prenatal information	☐ Progress notes	

4. By ***initialing*** the spaces below, I authorize the use/disclosure of the following information. Specific records requested must be listed below, e.g., assessment, treatment plan, discharge plan.

___ Drug/alcohol diagnosis, treatment or referral information requested: _____

___ HIV/AIDS related records requested: _____

___ Mental health related information requested: _____

___ Genetic testing information requested: _____

5. I understand that:

a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care.

b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

c. I may revoke this authorization at any time by notifying _____ in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

d. Federal privacy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

6. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.

_____ _____
(Signature of Parent, Legal Guardian, Student/Child) (Date)

_____
(Relationship)

This authorization expires on _____ (Month/Day/Year) (not to exceed one year from date of signature above).

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Authorization to Use and/or Disclose Educational and Protected Health Information

Purpose of form:

- This form was created so that educational agencies could request information from health entities that require HIPAA-compliant release forms. (HIPAA: Health Insurance Portability and Accountability Act)

- This form is used when there is a need to obtain consent from a parent, legal guardian or student/child to authorize the named agency to:
  - Send/disclose protected health information and/or educational information; and/or
  - Receive/use protected health information and/or educational information

Directions for completing form:

Box 1. Required.

- Enter the student/child's full legal name including middle name;
- Enter other names used by the child including nicknames;
- Enter child's date of birth;
- Enter the name and address of the health care provider who will send or receive requested protected health and/or educational information;
- Enter the name and address of the school district or EI/ECSE program sending or receiving the requested protected health and/or educational information; and
- Check all appropriate boxes that apply indicating which provider is authorized to send and which provider is authorized to receive protected health and/or educational information.

Box 2. Required.

- Mark all the boxes that apply regarding how the requested protected health and/or educational information will be used. For a record that is not represented in the list, check the "other" box and specify a different type of purpose.

Box 3. Required.

- Mark all the boxes that apply regarding which specific medical and/or educational records are being requested. For a record that is not represented in the list, check the "other" box and specify a different type of record.

Box 4. Required only if any of the four types of records indicated are requested. This box should be left blank if none of these four types of records are requested.

- The four types of records indicated require an additional level of protection. To request any record in Box #4, the specific type of record must be listed in the spaces provided and the parent, legal guardian or student/child must initial the space before each type of record requested. For example, for mental health information, a program might indicate "psychologist's assessment" and then the parent, guardian or student/ child would initial the space at the beginning of the mental health information line.

Box 5. Required.

- This box contains information relating to the parent's, guardian's, or child's rights in giving authorization including the right to refuse to sign, the right to request a copy after signing, the right to inspect the information to be used and/or disclosed, and the right to revoke the authorization. Information is given that clarifies that when requested information is sent, the laws that protect that information may no longer apply since the receiving agency may not be bound by the same laws as the sending agency.
- In item c., identify who will receive the potential revocation. The statement clarifies that if an action has already been taken, for example, protected health information has already been sent, then the revocation for that specific information is not valid. However, the agency may voluntarily return the information received after the revocation has been signed and submitted.

Box 6. Required.

- Parent, legal guardian, or student/child must sign for the authorization to be valid. If parent or guardian, the relationship to the child must be indicated. The date of the signature must be entered.
- The authorization is only valid for the purposes checked or stated in the form.

Box 7. Required.

- The month, day, and year that this authorization will expire must be included in the space provided. The date must not go beyond one year past the date of the signature.

Additional directions

- Place a copy of this form into the student/child's file.
- HIPAA requires that the school district/EI/ECSE program give a copy of the authorization form to individuals who sign it and request a copy. However, it is recommended practice that the school district/program automatically give the parent, guardian, or student/child a copy of the form after they have signed it, whether or not they request it, so they will have a record of the authorization.

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Autorización para usar y/o revelar información de educación y médica protegida

1. **Autorizo a los siguientes proveedores a usar y/o revelar información de educación y/o médica protegida sobre mi hijo.**

(Nombre del estudiante/niño) _____ (Fecha de nacimiento) _____

(Otros nombres usados por el estudiante/niño) _____ (Nombre de la escuela o del programa) _____

Nombre y dirección del proveedor de la salud autorizado a:

- ☐ Enviar/revelar información médica protegida
- ☐ Recibir/utilizar información de educación

Nombre y dirección de la escuela/programa EI/ECSE autorizado a:

- ☐ Enviar/revelar información de educación
- ☐ Recibir/utilizar información médica protegida

2. **Entiendo que esta información se utilizará para los siguientes propósitos (marque todo lo que corresponda):**

- ☐ Determinar la elegibilidad para servicios de Educación Especial, EI/ECSE u otros servicios
- ☐ Determinar los niveles actuales de desempeño del estudiante/niño
- ☐ Crear un plan de salud individualizado
- ☐ Crear un Programa de Educación Individualizado o Plan Individualizado de Servicios a Familias adecuados
- ☐ Otro (especifique): _____

3. **Al marcar las casillas siguientes, autorizo el uso/la revelación de los siguientes registros médicos y/o de educación específicos:**

☐ Declaración de elegibilidad del médico	☐ Información de educación	☐ Evaluaciones psicológicas
☐ Declaración de evaluación médica	☐ Documento IFSP/IEP	☐ Informes de trabajo social
☐ Antecedentes y examen físico	☐ Historias clínicas	☐ Otro: _____
☐ Registro médico completo	☐ Enfermedad(es) transmisible(s)	
☐ Información prenatal	☐ Notas de evolución	

4. **Al *poner mis iniciales* en los espacios siguientes, autorizo el uso/la revelación de la siguiente información. Los registros específicos que se solicitan se deben listar a continuación, por ejemplo, evaluación, plan de tratamiento, plan de alta.**

___ Diagnóstico de drogas/alcohol, tratamiento o información de referencia solicitada._____

___ Registros solicitados relacionados con VIH/SIDA:_____

___ Información sobre salud mental solicitada:_____

___ Información solicitada de pruebas genéticas:_____

5. **Entiendo que:**

a. Esta autorización es voluntaria y que puedo rehusarme a firmarla sin que eso afecte la atención médica de mi hijo.

b. Tengo el derecho de solicitar una copia de este formulario después de firmarlo, así como de revisar o copiar cualquier información a utilizarse o revelarse bajo esta autorización (si lo permiten las leyes del estado y las leyes federales. Consulte 45 CFR § 164.524).

c. Puedo revocar esta autorización en cualquier momento notificando por escrito a _____. Sin embargo, esto no afectará ninguna medida tomada antes de que la revocación fuese recibida ni ninguna medida tomada en base a información compartida previamente.

d. Las reglas federales de privacidad para la información médica protegida sólo se aplican a planes de salud, centros de intercambio de información de atención médica o proveedores de salud. Si autorizo la revelación de información médica a otras agencias o individuos, dicha información puede dejar de estar protegida por las regulaciones federales de privacidad.

e. Las reglas federales de privacidad para información de educación sólo se aplican a escuelas y programas EI/ECSE. Si autorizo la revelación de información de educación a otras agencias o individuos, dicha información puede dejar de estar protegida por las regulaciones federales de privacidad.

6. **Consiento a que se utilice/revele la información anteriormente mencionada. Entiendo que está prohibido el uso de esta información para cualquier otro motivo que los expresados en la declaración anterior. Este consentimiento puede ser revocado en cualquier momento, excepto en la medida que se haya procedido en base a información ya revelada.**

_____
(Firma del padre, tutor legal, estudiante/niño) (Fecha)

_____
(Relación)

Esta autorización vence en _____ (Mes/Día/Año) (no deberá exceder un año a partir de la fecha de la firma anterior).

JEFFERSON COUNTY ESD
Madras, Oregon

Confidential 504 Plan Information for Bus Drivers

Date:

Student's Name:

Parent/Guardian Name(s):

Address:

Phones: (H) (W) (Other)

Emergency Contact Information:

School: Select School

504 Eligibility:

Accommodations (condensed and specific to transportation):

8-27-07