Authorization to Disclose Information Including Children's Individual Identifiable Health Information

State of Kansas
Child Welfare Case Management Providers
State Board of Education
Department for Children and Families
Kansas Department of Corrections - Juvenile Services Division
(Pursuant to HIPAA Privacy Regulation, 45 C.F.R. ' 164.508)

A. AUTHORIZATIONS; INFORMATION COVERED; PERSONS AUTHORIZED TO MAKE AND TO RECEIVE DISCLOSURES; PURPOSES OF DISCLOSURES; MINIMUM NECESSARY INFORMATION; METHOD OF DISCLOSURES.

I, _____, am the (choose correct one:) ___ parent ___ legal guardian of the following minor child(ren) with authority to act on their behalf:

Full Name: _____ Date of Birth:_____
Full Name: _____ Date of Birth:_____
Full Name: _____ Date of Birth:_____
Full Name: _____ Date of Birth:_____
Full Name: _____ Date of Birth:_____

On behalf of the minor child(ren) named above, I hereby authorize the Kansas Department for Children and Families (DCF) and/or the Kansas Department of Corrections - Juvenile Services Division (KDOC-JS) and their employees, contractors, and agents:

(1) to disclose information about my child(ren) (including individually identifiable health information and protected health information, such as name, gender, date of birth, social security number, hearing and vision test information, out-of-home care provider, current medications, physical or mental conditions relevant to learning processes, and behaviors)

(2) to the Kansas State Department of Education; to any Kansas Unified School District that provides educational services to my child(ren); and to their employees, contractors, and authorized agents (the educational institutions)

(3) for the limited purpose of providing educational and related services to my child(ren).

I also authorize the disclosing organizations designated above and their employees, contractors, and agents:

(1) To make those authorized disclosures in any manner, including, but not limited to, orally, in paper documents, or electronically by e-mail, fax machine, or data entry into the Kansas State Department of Education database;

(2) To disclose only the minimum information necessary to enable the educational institutions to provide educational and related services to my child(ren); and

(3) To access, recall, edit, correct, update, and re-enter the information they previously entered or submitted for entry into the Kansas State Department of Education data bank.

B. LIMITATIONS AND CONDITIONS ON MY AUTHORIZATIONS. The disclosures of my child(ren)'s information that I am authorizing are subject to these limitations and conditions:

(1) No organization or person may make a disclosure if they have any reason to believe that recipient of the information will use any or all of the information for an unauthorized purpose.

(2) I make no other limitations or conditions on the disclosures I have authorized.

C. RE-DISCLOSURES OF INFORMATION BY AUTHORIZED RECIPIENTS. I understand that my child(ren)'s information will be disclosed to educational institutions that are required by Federal law (Family Educational Rights and Privacy Act, 20 U.S.C. 1232g) to maintain the confidentiality of that information. I also understand that the organizations and persons that I have authorized to disclose my child(ren)'s information have no control over the educational institutions that will receive the disclosed

information or over any re-disclosures of my child(ren)'s information that those educational institutions may make. Any re-disclosures of my child(ren)'s information by the educational institutions are subject to my control and to the applicable Federal law.

D. CONSEQUENCES OF NOT SIGNING AUTHORIZATION. I understand that if I do not authorize disclosures of my child(ren)'s information by signing this Authorization, the educational institutions in which my children are enrolled may be hampered in providing educational and related services to my child(ren).

E. EFFECTIVE DATE OF THIS AUTHORIZATION. This Authorization to disclose my child(ren)'s information to educational institutions is effective on the day I sign this Authorization.

F. EXPIRATION OF THIS AUTHORIZATION. This Authorization to disclose my child(ren)'s information to educational institutions expires on whichever date occurs first:

(1) The date on which my child(ren) is (are) no longer, by order of the court, in the custody of either the Secretary of DCF or the Secretary of KDOC.

(2) The date on which I deliver my written revocation of this Authorization to the organization(s) that I authorized in Section A, above, to make disclosures.

G. RIGHT TO REVOKE MY AUTHORIZATION. I specifically reserve the right to revoke this Authorization at any time. I understand that, for my revocation to be effective, I must revoke this Authorization in writing and deliver that written revocation or cause it to be delivered to the correct address for whichever of the following organizations that I authorized to disclose information:

- **Kansas Department for Children and Families,** ATTN: HIPAA Privacy Officer, 555 S. Kansas Ave., Topeka, KS 66603
- **Kansas Department of Corrections – Juvenile Services Division,** ATTN: HIPAA Privacy Officer, 714 SW Jackson, Suite 300, Topeka, KS 66603.
- I understand that DCF and JJA and their employees, contractors, and agents are authorized to continue disclosing information about my child(ren) to educational institutions until my written revocation of this Authorization is delivered to them.

My Name (Please Print): _____

My Signature: _____

Date of My Signature: _____

Authorization Received By:_____ Date:_____

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Kansas
Department for Children and Families
Prevention and Protection Services
Strong Families Make a Strong Kansas