AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTH CARE PROVIDERS AND SCHOOL DISTRICTS

Completion of this document allows the school nurse to contact your child's health care providers to obtain health related information that is required by the State of Pennsylvania.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Date of Birth: _____

I, the undersigned, do hereby authorize:

- ☐ **(Doctor's Name) _____**
- ☐ **(Dentist's Name)_____**
- ☐ **(Other health care provider) _____**

to exchange health information from the above-named child's medical record to and from the Tussey Mountain School District's Nursing Department.

The disclosure of health information is for the following purposes:

- **Record of Immunizations**
- **Record of Physical and or Dental Examinations**

DURATION:
This authorization shall become effective immediately and **shall remain in effect for two (2) years from date signed**, unless sooner revoked by me in writing.

YOUR RIGHTS:
I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I have a right to receive a copy of this Authorization

RE-DISCLOSURE:
I understand that the School District will not improperly disclose this information, as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that this information becomes part of the student's educational record upon being transmitted to a public school that receives federal funding. The information will be considered private and confidential, however the information may be shared with individuals working at the School District only when necessary for the purpose of providing safe, appropriate, and least restrictive educational settings, school health services, or other academic or extracurricular programs.

APPROVAL:
Parent/Guardian Signature: _____ Date: _____

Print Name: _____ Phone: _____