HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Form 1

Patient/Student Name: _____ Date of Birth: _____

I hereby authorize _____ [*health care provider name, address, and telephone]* to release my/ my child's health information/records for the purposes listed below to:

_____ *[name of school official]*

_____ *[name of school/school district]*

_____ *[school address and telephone]*

Description:
The information to be disclosed consists of: _____
_____

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

_____

Authorization:
This authorization is valid for one calendar year. It will expire on _____ *[date]*. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____ _____
Parent Signature Date

_____ _____
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form.

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

Form 2

Patient/Student Name: _____ Date of Birth: _____

I hereby authorize _____ *[health care provider name and title]* and _____ *[name and title of school official]* to exchange health and education information/ records for the purposes listed below:

_____ *[address & telephone of school/school district]*

_____ *[address & telephone of health care provider]*

Description:
The health information to be disclosed consists of:
_____
_____

The education information to be disclosed consists of: _____
_____

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

1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school
3. Medical evaluation and treatment
4. Other: _____

Authorization:
This authorization is valid for one calendar year. It will expire on _____ *[date]*. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____ _____
Parent Signature Date

_____ _____
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form.

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/ receiving the protected health information