(*Name of School)* PUBLIC SCHOOLS

HIPAA-Compliant Authorization for Release of Health Information

Patient/Student Name: _____ **Date of Birth**: _____

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

_____ [*insert name of school official*]

_____ [*insert name of school/school district*]

_____ [*insert 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 _____[*insert 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. In Maine, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, sexual assault evaluation and reproductive health care services.

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information Rev. 6/03

Form adapted from Ohio and Connecticut. Revised 6/03