

Authorization for Use and Disclosure of Protected Health Information and Education Records

Patient/Student Name: _____ Date of Birth _____

I hereby authorize:

_____ to disclose protected health information and/or educational records to:

Check here if authorization is given for the parties above to mutually exchange the information described below.

Description:

The health information to be disclosed consists of (check all that apply):

- Any and all records in the possession of _____ including mental health, HIV, and/or substance abuse records. (Cross out any item that you do not authorize to be released.)
- Records regarding treatment for the following condition or injury _____
- Records covering the period of time between _____ and _____
- Other (be specific, including dates): _____

The education information to be disclosed consists of (check all that apply)*:

- Any and all educational records, including permanent, temporary, and special education records.
- Records covering the period of time between _____ and _____
- Other _____

* Parents have the right to limit this consent to specific records or portions of records and can use this section to do so.

Purpose:

This information is to be disclosed at the individual's request and will be used for the following purpose(s) (check all that apply)

- Educational evaluation and program planning
- Health assessment / planning for health care services in school or medical treatment.
- Other: _____

This authorization is valid for one calendar year and will expire on _____

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health 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. I also understand that I have the right to inspect and copy educational records and to challenge their contents. I understand that a photocopy of this document is as valid as the original.

Parent Signature

Date

Student Signature*

Date

Witness Signature

Date

*Student signature required if the student is 12 or older and this authorization is for the release of mental health records.

PROOF OF IDENTIFICATION: Driver's License ____ State ID ____ Other (specify) _____