Authorization for Use or Disclosure of Student Health Information To and From School Districts (HIPAA)

Health Services

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

Use and Disclosure Information:

Patient/Student's Name: ____ ________________

Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) ____

(2) ____

to provide health information from the above named student's medical record to and from:

Consolidated School District 158
650 Academic Drive
Algonquin, Illinois 60102

____ ______________________________

Name of District 158 Contact Person (please print) Telephone Number

The disclosure of health information is required for the following purpose: ______________________________

____

Requested information shall be limited to the following:

☐ All minimum necessary health information ***or***

☐ Disease specific information as described: ______________________________________

Duration: This authorization shall become effective immediately and shall remain in effect until ______________ (enter date) ***or*** for one year from the date of signature, if no date entered.

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 health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor (District 158) or others have acted in reliance to this Authorization.

Re-Disclosure: I understand that the Requestor (District 158) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with District 158 for the purpose of providing a safe, appropriate, and least restrictive educational setting and school health services program. I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

Approval:

______________________________________ ______________________________________

Name of Parent/Guardian (please print) Signature of Parent/Guardian Date

______________________________________ ______________________________________

Relationship to Patient/Student Telephone Number