School Administrative Unit #24

HIPAA-Compliant Authorization for Exchange of Health & Education Information

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

I hereby authorize
to release my child's health information/records for the purpose listed below to:

Description:
The information to be disclosed consists of:

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

Authorization

This authorization is valid for one calendar year. It 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 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.

_____

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 11/23/16

Form adapted from Ohio and Connecticut