HIPAA Compliant Release of Information Form
Authorization to Release Protected Health Information

____ _______________________
Print student's full name Student's date of birth

____ _______________________
Print name of Parent/Guardian Daytime Phone number

Physician or healthcare facility records requested from:
____ Fax ____________________
____
____
____

Send requested health record information to:
Name of recipient __________________________________ Fax ___________________
School address _____________________________________
____

Applicable Dates/Encounters (specify):____

The following information is to be released (Check all that apply):
□ Doctor's orders □ Health care plan for school management
□ Emergency room record □ Immunization records
□ Neuropsychological reports □ Records from _________________________
□ PE/Activity restrictions ______________________________________

Medical records received will become part of the student's educational record. These records will move from school to school with the student. The principal and school nurse are allowed to review these records upon arrival to the school to which the student has transferred. Any disclosure of this medical information by the recipient(s) is prohibited except when implicit in the purpose of this authorization. Check below those who are authorized to receive this health information:
□ School nurse/clinic staff □ Principal □ Student Support Team
□ Bus driver/monitor □ Student's teachers □ Cafeteria staff
□ Other school staff or classmates (specify) _____________________________________

The purpose for which this release is being requested is:
□ Continuing health care in school □ Educational accommodations

This authorization expires:
□ 12 months from date of signature or □ Specified date ____________________

I understand that I have the right to revoke this authorization in writing at any time.

____ _______________________
Parent/ Guardian Signature Date