

**AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION
FROM HEALTH CARE PROVIDERS TO SCHOOL DISTRICT**

Section I. Student Information

This form provides authorization to release information related to personal health information of the following student:

Name: _____ Date of Birth _____

Address: _____ Telephone: _____

Section II: Disclosure and Use of Personal Health Information

I hereby give my permission to _____
to use and disclose my personal health information in the manner described below.

Section III: Description of Personal Health Information to be Disclosed

Describe the personal health information you are authorizing to be disclosed (ie., immunization records, all medical records related to treatment for ADHD, all medical records relating to treatment of depression, etc.)

Section IV: Description of Persons or Entity Authorized to Receive and Use Personal Health Information

Authorized representatives at _____ School District, which is located at _____, phone number is _____ have my permission to received and use the above-referenced personal health information.

Section V: Purpose of this Authorization

The purpose of this disclosure of personal health information is:

- To aid in making present and future educational decisions.
- Other: _____

Section VI: Expiration and Revocation

This authorization may be revoked (canceled) at any time except to the extent that the provider has already released personal health information prior to the revocation of this authorization. Requests for revocation must be in writing. To revoke the authorization, contact _____ at _____.

If not revoked, this authorization will expire one year after the date on which the authorization is signed.

Section VII. Signature and Refusal to Sign this Authorization

I acknowledge that this authorization is voluntary. I understand that I am not required to sign this authorization as a condition of receiving health care treatment unless such treatment is solely for the purpose of creating personal health information for disclosure to _____ School District under this authorization. I acknowledge that I have received a written copy of this authorization.

I understand that if the persons or organizations I authorize to receive and/or use my personal health information described in this form are not health plans, covered health care providers, or health care clearinghouses subject to the federal privacy laws, they may further disclose my personal health information and it may no longer be protected by the federal privacy laws.

I acknowledge that I have read and understand this form.

Signature: _____ Date: _____

If a personal representative (for example, a spouse, parent, durable power of attorney for health care, etc.) signs this form on behalf of the individual in Section I. Please complete following:

Representative's Name: _____
Relationship: _____
Date: _____