DEPARTMENT OF STUDENT SUPPORT SERVICES
OFFICE OF HEALTH SERVICES

HIPAA-Compliant Authorization for Release of Health Information

Student Name _____ **Date of Birth**_____

I hereby authorize_____ to release
Primary Care Provider, Address, and Phone

my/my child's health information records for the purpose listed below to:

School Nurse _____ Phone _____

School _____ Grade _____ Room # _____

Address _____

Description:
The information to be disclosed consists of:

_____

_____

_____

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

- ☐ Educational evaluation and program planning.
- ☐ Health assessment and planning for health care services and treatment in school.
- ☐ Medical evaluation and treatment.
- ☐ Other _____

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 these 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. In Missouri, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for STD-HIV/AIDS, reproductive health care services, and general medical care.

Copy = Primary Care Provider **Copy = Parent or Student*** **Original = School Health File**