Blount County Schools

Name of School _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM SCHOOLS

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

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ _____/_____

Last First MI Date of Birth

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

(1)_____ (2) _____ to provide health information from the above-named child's medical record to and from:

_____

School District to Which Disclosure Is Made **Address / City and State / Zip Code**

_____

Contact Person at School District **Area Code and Telephone Number**

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: _____

Type of Information to be Released: (Check and initial <u>all</u> that apply.)

☐ Auditory, speech, vision reports	_____	☐ Medication Orders	_____
☐ Physical and/or Occupational Therapy reports	_____	☐ Medical Records	_____
☐ IEP/504 Related Medical Data	_____	☐ Medical Testing, Lab Records	_____
☐ Genetic Testing Records	_____	☐ Psychiatric, Psychological, Counseling Records	_____
☐ Immunization Records	_____	☐ Other Records _____	
☐ Treatment Procedures/Orders	_____		

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 or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor (School District) 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 the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

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:_____ _____ _____

Printed Name **Signature** **Date**

_____

Relationship to Patient/Student **Area Code and Telephone Number**