Scholastic / Student Records
FERPA/HIPAA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTH CARE PROVIDERS AND SCHOOL DISTRICTS

Completion of this document allows the disclosure and/or use of individual identified education records and health information, as set forth below, consistent with Federal laws (including 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 agency and/or health care providers):

(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

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

The disclosure of health information is required for the following purpose:

_____

Description of Information to be Disclosed: I authorize the release and disclosure of any and all medical records, histories, reports, notes, diagnostic films or imaging, and all such other health information pertaining to [Name of Child], a minor, of whatever kind and character, and including but not limited to any psychiatric, psychological or mental health records, from [Date] to the date this release is presented for such records, to the persons/entities identified herein.

DURATION:

This authorization shall become effective immediately and shall remain in effect until for one year from the date of signature, unless sooner revoked by me in writing.

RESTRICTIONS:

Law prohibits the School District from making further or different disclosure of the health information contemplated by this Consent form unless another authorization form is obtained from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My refusal 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. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

RE-DISCLOSURE:

I understand that the School District will not improperly disclose this information, as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that this information becomes part of the student's educational record upon being transmitted to a public school that receives federal funding. 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, school health services, or other academic or extracurricular programs.

I have a right to receive a copy of this Authorization. Signing the Authorization may be necessary in order for this student to obtain appropriate services in the School District.

APPROVAL:

Printed Name	Signature	Date

Relationship to Patient/Student	Area Code and Telephone Number

RELEASE RECORD TO COPY SERVICE:

RECORDS DEPOSITION SERVICE, INC.

120 W. MADISON STREET, SUITE 300

CHICAGO, IL 60602

P: 312-553-8900 F: 312-553-8901