



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM DOUGLAS COUNTY SCHOOL DISTRICT/ Health Services

Completion of this document authorizes the disclosure and/or use of individually identifiable 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.

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 Code

Contact person at School District Phone number of contact

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

Requested information shall be limited to the following:

- All minimum necessary health information
- Mental health related records
- Disease specific information as described:

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature if no date entered.

YOUR RIGHTS: I understand that the following rights with respect to this Authorization: I may revoke the 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 Douglas County 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 the 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 Phone Number