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| **HEALTH SERVICES** | **HIPAA-Compliant Authorization for**  **Release of Health Information** |

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| --- | --- | --- | --- |
| **Student/Patient Name:** |  | **Date of Birth:** |  |

|  |  |
| --- | --- |
| I hereby authorize |  |
| (insert health care provider name, address and telephone number) to release my child’s health information/ records for the purpose listed below to: | |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| (Name) |  | (Title) |

St Johns County School District

40 Orange Street

St Augustine, FL 32084

|  |  |
| --- | --- |
| Description: |  |
| The information to be disclosed consists of: |  |
|  |  |

|  |  |
| --- | --- |
| Purpose: |  |
| This information will be used for the following purpose(s): |  |
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|  |  |
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| **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 notifying the “Sent FROM” organization noted above in writing. 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. | | |

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|  |  |  |
| 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

Copies: Parent or student\*

Physician or other health care provider releasing the protected health information

School official requesting/receiving the protected health information