HIPAA-Compliant Authorization for Exchange of Health and Education Information

_____ _____
Student Name Date of Birth

I hereby authorize _____**and/or**
(insert name and title of school official)

_____ **to exchange health and education**
(*insert name of health care provider and title)*

information for the purpose listed below.

_____
Address and telephone # of school/school district.

_____
Address and telephone # of health care provider.

Description: The **health information** to be disclosed consists of:

Description: The **education** information to be disclosed consists of:

Purpose: This information will be used for the following purpose(s):
1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school

3. 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 withdrawal of my consent. I recognize that health records, once received by the school, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Education 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/ Guardian Signature_____ Date_____

Parent/ Guardian Printed Name_____