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 notice of the withdrawal of my consent. 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.

_____

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 the student shall sign this authorization form.

Copies: Parent or student* ; school official requesting/receiving the protected health information
Physician or other health care provider releasing the protected health information

HAMPTON-DUMONT COMMUNITY SCHOOLS

HIPAA-Compliant Authorization for Release of Health Information

Patient-Student Name:_____ Date of Birth:_____

I hereby authorize _____
_____
(*insert health care provider name, address, and telephone)* to release my child's health information records for the purpose listed below to:

Ann Bobst, School Nurse _____(*school official)*

Hampton-Dumont Community School _____*(school district)*

601 12th Avenue N.E. _____*school address/phone)*

Hampton, IA 50441 Phone 641-425-8071 _____

Description:
The information to be disclosed consists of:
Medical information and appropriate treatment in school setting for any medical condition.

Purpose:
Inform staff having a need to know any pertinent medical condition that may affect student in the school setting .

Authorization

This authorization is valid for one calendar year. It will expire on 8/18/12. I understand that I may