

TEKOA SCHOOL DISTRICT

AUTHORIZATION FOR EXCHANGE OF HEALTH CARE INFORMATION

Patient/Student Name

Birthdate

I hereby authorize the exchange of health and education information:

Between School District Staff (listed below)

and:

School Nurse

Phone

Name of Agency/Individual

Phone

Health Coordinator

Phone

Address

Other

Phone

City, State, Zip Code

Specific nature of information to be disclosed:

Purpose for which disclosure is being made:

I hereby authorize the exchange of health care information as described above. I recognize that this information, once received by the school district, may no longer be protected by the HIPAA Privacy Rule and become educational records protected by the Family Education Rights and Privacy Act (FERPA), but will be handled in compliance with applicable state and federal laws and school district policies and procedures.

This authorization expires with end of the school year or _____, whichever is sooner. I may terminate this authorization in writing at any time. I have a right to a copy of the authorization and may inspect and receive a copy of the disclosed or used information.

Parent Signature

Date

Student Signature *

Date

* If the student is a minor but is authorized to consent to health care without parental consent under federal and state laws, only the student shall sign this form.

HIV/AIDS, STDs status, diagnosis, treatment

14 years of age

Family Planning/Abortion

No age limit

Alcohol/Drug Treatment

13 years of age

Mental Health Services

13 years of age

(Envelope shall be marked "CONFIDENTIAL")