



Clarksville Montgomery County School System
HEALTH SERVICES

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
TO and FROM SCHOOL DISTRICTS

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 the information requested may invalidate this authorization.
USE AND DISCLOSURE INFORMATION:

Patient/Student Name: Last First MI / DOB

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) (2)

To provide all health information from the above-named child's medical record to:

School District Address/city and state/zip
Contact person at school Area code with phone number

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

Requested information shall be limited to the following: [] All minimum necessary health information; or [] Disease-specific information as described:

(if neither box is checked, no limit applies, and all health information will be disclosed)

DURATION:

This authorization shall become effective immediately and shall remain in effect until (enter date)
Effective for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization. I may revoke this 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 education record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs. A photocopy of this Authorization is effective and valid as the original.

This is an authorization for release of documents and does/ does not permit verbal discussion of the records.

I have the right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL

Printed Name:

Relationship to Student: Phone Number: ()

Signature: Date: