MONROE COUNTY
COMMUNITY SCHOOL CORPORATION
ENGAGE. EMPOWER. EDUCATE.

Health Services Department

Patient/Student Name: ________________________________ Date of Birth: _________

I hereby authorize ________________________________[insert health care provider name title] and

____ [insert name & title of school official] to exchange

health and education information/records for the purpose listed below.

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[Insert address & telephone of school/school district]

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Description

The health information to be disclosed consists of:

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. Medical evaluation and treatment
4. Other: ____

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Authorization

This authorization is valid for one calendar year. It will expire on _________________ [insert date]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health 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

Copies: Parent/guardian of student
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information