HAYSVILLE PUBLIC SCHOOLS

U.S.D. #261

HIPAA-Compliant Authorization for Exchange of Health & Education Information

School: _____

Name of Student: _____ Date of Birth: _____

I hereby authorize _____ [insert health care provider name & title]
_____ [insert address & telephone of health care provider]
and _____ [insert name of school] to exchange health and education information/records for the purpose listed below.

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

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. Kansas Immunization Registry (Immunization information disclosed to the registry will be used for purpose of assessment and reporting to prevent disease)
4. Sedgwick County Health Department (assessment and reporting to prevent disease)
5. Other: _____

Authorization:
I affirm that I am authorized to consent to release of medical information on behalf of the Student. I understand that this authorization will expire when the Student is no longer enrolled in the above-named school district and 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
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information