

ANDALUSIA CITY SCHOOLS
HIPAA Compliant – Authorization/Request For Record(s) Form

This form should be used when requesting, releasing, authorizing, obtaining, or sharing of student records or information (verbal or written) as requested by parents or as needed by Andalusia City Schools. This authorization is valid to use with Outside Agencies, Contract Service Providers, Health Care Providers, Educational Institutions, or Other Related Agency as specified.

Agency: _____

Patient/Student Name: _____ Date of Birth: _____

I hereby authorize _____ [Insert agency name & title]

And _____ [insert name and title of school official]

To exchange health, education, or other relevant information/records for the purpose listed below.

_____ [insert address & telephone of school/school district]

_____ [insert address and telephone of health care provider]

Description of Information (i.e. health, educational, or other) to be released:

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: _____

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. **Is notarized signature required?** _____ YES _____ NO

Parent Signature Date

Student Signature Date

Notary 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.

**Notary Signature may be required if indicated in the above "Authorization" paragraph.

Copies: Parent or Student*
Physician or other healthcare provider releasing the protected health information
School official requesting/receiving the protected health information