HIPAA-Compliant Authorization for Exchange of Health and Education Information

Patient/Student Name: _____ **Date of Birth:** _____

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

and _____ [*insert name and title of school official*] to exchange health and education information/records for the purpose listed below.

_____ [*insert address and telephone of school/school district*]

_____ [*insert address and telephone of health care provider*]

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) (circle all that apply):

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.

_____

Parent Signature Date

_____

Student 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. In Michigan, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.

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