Clinton
PUBLIC SCHOOLS

HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient/Student Name: _____ Date of Birth: _____

I hereby authorize _____

[Health care provider name, address and telephone number]

to release my child's health information/records for the purpose listed below to:

_____[name of school official]

_____ [school/school district]

_____ [school address and telephone]

Description:

The information to be disclosed consists of: _____

_____

_____

Purpose:

The information will be used for the following purposes:_____

_____

_____

Authorization

This authorization is valid for one calendar year. It will expire on _____ *[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 these 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/Guardian Signature Date

_____ _____

Student Signature* Date

Administrative Offices | 137-B Glenwood Road | Clinton, CT 06413 | Phone: 860-664-6500 | Fax: 860-664-6580

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*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 Connecticut, 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

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