Bradley-Bourbonnais Community High School

HIPAA-Compliant Authorization for Exchange of Health Information

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

Graduation Year _____ Telephone____-____-_____ Email_____

I hereby authorize _____ [*insert health care provider name & title, University Name or self*]

and Bradley- Bourbonnais Community High School to exchange health information/records for the purpose listed below.

_____ [*insert address, fax number, or email of health care provider, University or self to which the information is to be sent along with a phone number for the institution*]

Please note that it may take up to 48 hours or more to complete the transfer of health records and cannot be accessed when school is not in session.

Description:
The health information to be disclosed consists of:

_____ School Physical

_____ Immunization Record

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.

_____

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 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

PSA - Rev. 4/15/03

By CT State Department of Education, Nadine Schwab, & CT Chapter, American Academy of Pediatrics; adapted format from Ohio.