ST. JOHNS COUNTY SCHOOL DISTRICT

HEALTH SERVICES

HIPAA-Compliant Authorization for Release of Health Information

Student/Patient Name: ______________________________ **Date of Birth:** ______________

I hereby authorize ____
(insert health care provider name, address and telephone number) to release my child's health information/ records for the purpose listed below to:

______________________________ ______________________________
(Name) (Title)

St Johns County School District
40 Orange Street
St Augustine, FL 32084

Description:
The information to be disclosed consists of: ______________________________
____

Purpose:
This information will be used for the following purpose(s): ______________________________
____
____
____

Authorization

This authorization is valid for one calendar year. It will expire on ______. I understand that I may revoke this authorization at any time by notifying the "Sent FROM" organization noted above in writing. 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 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

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