ST. JOHNS COUNTY SCHOOL DISTRICT

Health Services

HIPAA-Compliant Authorization for Release of Health information

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

I hereby authorize: _____ [*insert Health care provider name, address and telephone*] to release my/my child's health information/records for the purpose listed below to:

Rosemary Newbern LPN
Name Title

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

Description:
The information to be disclosed consists of:

Medications and treatments

Purpose:
The information will be used for the following purpose(s):

effective care at school

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 submitting written notice to Health Services, 40 Orange St., Saint Augustine, FL 32084, 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 Education 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

PSA