THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

HIPAA AUTHORIZATION FOR RELEASE / REQUEST OF STUDENT HEALTH INFORMATION

I hereby request and authorize _____
(Name of Person and/or Hospital/Health Care Provider)
_____ to engage
(Street Address) (City) (State) (Zip) (Telephone #)

in verbal and/or written communication with and release records to: _____
(Name of Person and/or School)
_____
(Street Address) (City) (State) (Zip) (Telephone #)

Regarding the **information checked below** concerning my child _____, whose date of birth is _____. I understand that information concerning psychiatric, medical diagnosis, drug or alcohol abuse and educational information regarding my child may be released and/or communicated. I further understand that the records may contain information regarding my family, in addition to my child.

_____Health/Medical Records
_____Treatment Plans
_____Discharge Summaries
_____Case/Progress/Therapy Notes
_____Other
_____Other_____
_____Other_____

_____Substance Abuse Treatment Records
_____Social and/or Developmental History
_____Psychological and/or Psychiatric Evaluations and/or Reports
_____HIV/AIDS test results or related conditions (to disclose or receive this information, specific individuals must be named above)

For the Purpose of:_____

TERMS & CONDITIONS:

- The parent/guardian agrees to authorize the above named individuals/organization to access his/her confidential healthcare information only for the purpose listed above.
- Re-disclosures of information by the recipient authorized above may not be protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.
- The parent/guardian is voluntarily signing this authorization.
- The parent/guardian will receive a copy of the signed authorization.
- The parent/guardian reserves the right to refuse to sign this authorization. Enrollment, treatment, payment or eligibility for benefits will not be affected.
- The hospital, health care provider, or School Board staff will release only the minimum amount of information necessary to fulfill a request.
- The parent/guardian reserves the right to revoke this authorization at any time. The revocation must be in writing and sent to the child's school principal.

All information I authorize to be released or requested will be held strictly confidential and cannot be released by the recipient without an additional written consent, except as allowable by law. I understand this authorization will expire one (1) year after the date signed, or on _____, 20____, whichever is earlier. A copy of this authorization is valid in lieu of the original. I further understand I may withdraw this authorization consent at any time.

_____ _____
Print Name of Parent/Guardian/Eligible Student Signature of Parent/Eligible Student Date

_____
Relationship to Child

(USE THIS SPACE IF AUTHORIZATION IS WITHDRAWN)

_____ _____
Date Consent Is Withdrawn Signature of Parent/Legal Guardian