Gulf Shores City Schools

300 East 16th Avenue Gulf Shores, Alabama 36542

Student Name: _____Date of Birth_____

Address_____

Phone Number: _____ SSN_____/_____/_____

Check the one that applies: Use of PHI _____ Disclosure of PHI_____ Obtaining PHI_____

PHI to be used, disclosed or obtained: (Circle if ALL apply or check specific items below)

____Discharge Summary _____X-ray Reports ____Other (specify)

____Operative/Procedure Reports _____History & Physical

____Pathology/Laboratory Reports _____Information Concerning Medical/Psychological diagnosis

Purpose of Use and/or Disclosure of PHI:

_____Educational evaluation and program planning

_____Health assessment and planning for health care services and treatment in school.

_____Medical evaluation and treatment

_____Psychological Evaluation and development of Individualized Educational Program

Other: _____

_____

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 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 basic health care.

_____ _____

Signature of Parent/Legal Guardian Date

Please mail or send correspondence to:

Gulf Shores City Schools

School Name:

Address:

City, State, Zip

Fax Number

ATTN:

06/2019