School Year _______

Park Nicollet
HealthPartners®

DIAMONDHEAD CLINIC
CONSENT TO SHARE LIMITED INFORMATION

I give permission for Diamondhead Clinic to provide limited information about my child to employees of Burnsville–Eagan–Savage School District who are involved in health center operations.

I understand that a school employee provides some administrative services to Diamondhead Clinic**.** These services may include things like helping make appointments, getting signatures on forms, and helping communicate with the school nurse if the school nurse is also involved in my child's health care. The school employee will keep all information he or she obtains about my child confidential and will not share it with others at the school, except as needed to coordinate my child's care.

Student name ____ **Date of birth** _________________

Signature ____ **Date** _______________________

Relationship to student ____

This permission is valid for one year from the date of signature unless I revoke it.

Please return signed form to _____________________________