LEE'S SUMMIT R-7 SCHOOLS
Learning for Life

HIPAA AUTHORIZATION FORM FOR RELEASE OF MEDICAL AND HEALTH-RELATED INFORMATION

Student/Patient's name: _____

Student/Patient's address: _____

Date of Birth: _____

I hereby authorize use or exchange of protected health information, verbal or written about my student as described below.

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure: _____.
   [name of health care entity or professional from whom information is sought]
2. The following person or class of persons may exchange protected information regarding above student.

   Members of _____'s Education Team at:
   [name of school] _____
   [address of school] _____
   _____
   [telephone of school] _____
   [facsimile of school] _____
3. In addition to verbal exchange, the information covered by this authorization include:

   Any records pertaining to _____, including but not limited to any
   [name of student]
   and all medical and/or hospital charts to include all:

   - ☐ office notes
   - ☐ histories
   - ☐ diagnoses
   - ☐ laboratory reports
   - ☐ physician's orders
   - ☐ physician's progress notes
   - ☐ nursing progress notes
   - ☐ admission and discharge summaries
   - ☐ physical therapy/rehabilitation records
   - ☐ graphic records
   - ☐ radiology reports
   - ☐ CT reports
   - ☐ emergency room records
   - ☐ pharmacy and prescription records
   - ☐ any data pertaining to substance or alcohol abuse
   - ☐ any test scores/evaluations/reports
   - ☐ psychiatric/psychological records, correspondence
   - ☐ diagnostic studies
4. The purpose of obtaining the records is to plan and provide educational and health related services for:
   _____.
   [name of student]
5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
6. I may revoke this authorization by notifying _____
   [name of appropriate health care professional or school official]
   in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization form.
7. This authorization expires on _____

A copy of this completed, signed and dated form must be given to the parent/guardian.

I am the parent/guardian of _____ and, therefore, have the authority to sign
[student name]
this authorization to release medical or health-related information.

_____	_____	_____
Signature of Guardian	Current Date	Date of Birth

White - Health Services Yellow - School Record Pink - Parent

Revised 12/10