

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal laws (e.g., HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

_____ to provide health information from the above-named child's medical record to and from:

_____ Friendship School _____ 525 Third Street, Imperial Beach CA 91932
School to Which Disclosure is Made Address / City and State / Zip Code

_____ Mia Sneag, School Nurse _____ (858) 290-5510
Contact Person at School District Area Code and Telephone Number

Disclosure of health information is required for the following purpose:

DURATION:

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature.

SAN DIEGO HEALTH CONNECT:

By signing this, I understand that I give Friendship School access to my child's health information on San Diego Health Connect.

RESTRICTIONS:

California law prohibits Friendship School from making further disclosure of my child's health information unless Friendship School obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must in writing, signed by me or on my behalf, and delivered to Friendship School. My revocation will be effective upon receipt but will not be effective to the extent that Friendship School or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that Friendship School will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with Friendship School for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL: _____
Printed Name Signature Date

_____ Relationship to Patient/Student _____ Area Code and Telephone Number