

# ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services

## STUDENT RECORD RELEASE

(To Be Completed by Parents/Legal Guardians)

HIPAA – Compliant Authorization for Exchange / Release of Immunizations / Health / Education Information

Patient/Student's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

<b>Written*</b>	<p><i>Written exchange of information relevant to reason for this request.</i></p> <p>I hereby authorize _____  <span style="display: block; text-align: center; font-size: small;">(insert name, title, address, and telephone number)</span></p> <p>to release my child's health/immunization or education information, records, or documents for the purpose(s) listed below to _____  <span style="display: block; text-align: center; font-size: small;">(insert name, title, address, and telephone number)</span></p>
<b>Verbal*</b>	<p><i>Verbal exchange of information relevant to reason for this request.</i></p> <p>I hereby authorize _____  <span style="display: block; text-align: center; font-size: small;">(insert name, title, address, and telephone number)</span></p> <p>and _____  <span style="display: block; text-align: center; font-size: small;">(insert name, title, address, and telephone number)</span></p> <p>to verbally exchange my child's health/immunization and education information/records for the purpose(s) listed below:</p>

\* Information will be communicated only via the completed box(s) above.

**Description:**  
 The information to be disclosed consists of:

<input type="checkbox"/> Immunizations as Required by Annotated Code of Maryland, Educ §7-403	<input type="checkbox"/> Special Education Records
<input type="checkbox"/> Medication Order	<input type="checkbox"/> Psychological/Psychiatric Evaluation
<input type="checkbox"/> Treatment Order	<input type="checkbox"/> Official School Records
<input type="checkbox"/> Other Medical Records _____	

**Purpose:**  
 This information will be used for the following purpose(s):

<input type="checkbox"/> Admission to School	<input type="checkbox"/> Medical Evaluation and Treatment
<input type="checkbox"/> Educational Evaluation and Program Planning	<input type="checkbox"/> Health Assessment and Planning for Health Care Services and Diagnosis in School
<input type="checkbox"/> Other _____	

**Authorization:**  
 I, (name of parents/legal guardians) \_\_\_\_\_, authorize the disclosure of the above specified health/immunization and educational records to the individuals affiliated with the school as indicated above. I understand that, if the persons or organizations I authorize to receive and/or use the immunization records are not subject to the federal or state health information privacy laws, they may further disclose the immunization records, in which case, it may no longer be protected by the health information privacy laws.

This authorization is valid for one calendar year. It will expire on \_\_\_\_\_ (insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these 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 (FERPA) and become part of the student's cumulative record. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Parent's/Legal Guardian's Signature	Date
Name Printed, Address and Telephone Number	
Student's Signature*	Date

\* If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Maryland, a competent minor, depending on age, can consent to outpatient mental health care, drug and alcohol abuse treatment, testing for HIV/AIDS, and reproductive health care services.

Copy: Parents/Legal Guardians or student\*  
 Copy: Physician or other health care provider releasing the protected health information  
 Copy: School official requesting/receiving the protected health information