Davis School District
Authorization for Release and Use of Health Information

Student: **Date of Birth:**

I authorize the release of the above-named student's health information (as designated below)

From:
Address:
City/State/Zip:

To:
School or District:

The released information will be used for the following purposes (Please **check** all that apply):

☐ Educational ☐ Medical ☐ Personal
☐ Legal ☐ Other

Specific information to be released (please check all that apply) for treatment dates from _____ to _____.

☐ Complete Records
☐ Special Education Records
☐ Assessment Results
☐ Speech / Language Reports
☐ Other:
☐ Immunization Records
☐ Psychological Reports
☐ Mental Health Reports
☐ Physical / Occupational Therapy Records
☐ Interventions Summary
☐ Consultation Reports
☐ Discharge Summary
☐ Progress Notes

This authorization shall remain in effect for six (6) months from the date of signing. I understand that I have the right to revoke this authorization to the school and student's physician on behalf of my minor child by providing written notice to the health care provider consistent with the health care provider's policies. Revocation does not affect releases of medical records made prior to the revocation.

I understand that the health care provider is not responsible for any further disclosures of the released information by the school/district. I also understand that the released medical records may become part of the student's educational records and may be forwarded to another school in which the student seeks or intends to enroll. The school and district will protect this information in compliance with the Family Educational Rights and Privacy Act (FERPA).

Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records may be required in order for the school to implement an appropriate plan of education, learning accommodations/modifications, and or health care.

I understand that if I authorize release of the above information to any individual or entity that is not legally required to keep it confidential, the information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996, or any other state or federal law.

I understand that I have a right to receive a copy of this form after signing and I may inspect the information that is disclosed. By my signature below, I authorize the release and use of the information in accordance with the rights, restrictions and understandings above.

_____ _____
Signature of Parent/Legal Guardian/Student at Age of Majority Date

_____ _____
Signature of School Authority Date

Authorization Expires _____