# HIPAA Authorization Form
# (Incoming PHI)

**Avon Grove Charter School**
**110 E. State Road**
**West Grove, PA 19390**
**Phone: 484-667-5000 Fax: 610-869-5892**

**Kristen Bishop**
Head of School

I, _____, herby authorize _____
[*Parent name of student unless student is 14 or older]* [*Name of Doctor/Therapist or Organization]*

to use and/or disclose my son's/daughter's _____ (DOB _____)

protected health information described below to _____
*[Name(s) and Title(s)]*

of Avon Grove Charter School.

My protected health information will be used or disclosed upon request for the following purposes [please name and explain each purpose *such as: to provide appropriate educational programming]*

_____

_____

This authorization for use and/or disclosure applies to the information described below [mark those that apply]:

____ Any and all records in the possession of _____
*[Name of Organization providing the information]*
including mental health, HIV, and/or substance abuse records. [Cross out any item you do not authorize to be released]

____ Records regarding treatment for the following condition or injury _____

_____ on or about _____.

____ Records cover the period of time _____ to _____.

____ Other [please specify including dates] _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Mrs. Kristen Bishop, Head of School. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that once the Avon Grove Charter School receives my protected health information, it will be placed in my student record and become part thereof. As part of my student record, the disclosure and confidentiality of my health information will be governed by the Family Educational Rights and Privacy Act (FERPA) and not the Health Insurance Portability and Accountability Act (HIPAA).

I understand that I do not have to sign this authorization and that Avon Grove Charter School may not condition treatment or payment on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient in accordance with FERPA and no longer protected by HIPAA regulations regarding the privacy of my protected health information.

This authorization expires on [please list a specific date or event] _____
[usually one year]

I certify that I have received a copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative (please print)

_____
Description of Personal Representative's Authority