

# AUTHORIZATION FOR RELEASE OF IMMUNIZATION / TB RECORDS TO COMPLY WITH ALASKA'S "NO-SHOTS NO-SCHOOL" LAW

The purpose of releasing this information is to allow schools, childcare facilities and other centers that house school-age children to comply with Alaska's "No-Shots No-School" law. In many cases, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires written authorization before personal medical information can be released by a health care provider or health care organization. This form authorizes only the release of immunization records and/or confirmation of tuberculosis screening. **I understand that this does not authorize release of any other personal medical information.**

Name of child / student: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Name of parent / guardian: \_\_\_\_\_

Health care provider / organization releasing information: \_\_\_\_\_

School / organization requesting information: \_\_\_\_\_

Description of information to be released (check one or both):

- Immunization records
- Tuberculosis screening and results

I hereby authorize the disclosure of immunization records and / or tuberculosis screening information as described above. I understand that this authorization is voluntary. I understand that a health care provider may not condition treatment on whether I sign this authorization. I understand that if the person(s) or organization(s) authorized to receive this information is not a health plan or health care provider, the released information *may* no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may revoke this authorization at any time by notifying the organization releasing this information in writing. If I do revoke this authorization, I understand it won't affect actions taken before my revocation was received. I understand that I may request a copy of this authorization.

Please check **ONLY** one:

- I additionally authorize the re-disclosure of immunization records and/or tuberculosis screening information to other school or health care authorities should my child move to another school or school district **AND I understand that this authorization to re-disclose will expire when the student reaches the age of majority or when this authorization is revoked.**
- I **DO NOT** authorize further re-disclosure of this information and request that this authorization expire:
  - \_\_\_ When student moves or graduates from the school or organization listed above or when this authorization is revoked.
  - \_\_\_ Other (specify date): \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Printed name of parent or guardian: \_\_\_\_\_

Today's date: \_\_\_\_\_