LIND/RITZVILLE COOPERATIVE SCHOOLS

AUTHORIZATION FOR ***EXCHANGE*** OF HEALTH CARE INFORMATION

Patient/Student Name _____ Birthdate _____

I hereby authorize the exchange of health and education information:

Between School District Staff (listed below) **and:**

School Nurse _____ Phone _____ Name of Agency/Individual _____ Phone _____

Health Coordinator _____ Phone _____ Address _____

Other _____ Phone _____ City, State, Zip Code _____

Specific nature of information to be disclosed:

_____

_____

_____

Purpose for which disclosure is being made:

_____

_____

I hereby authorize the exchange of health care information as described above. I recognize that this information, once received by the school district, may no longer be protected by the HIPAA Privacy Rule and become educational records protected by the Family Education Rights and Privacy Act (FERPA), but will be handled in compliance with applicable state and federal laws and school district policies and procedures.

This authorization expires with end of the school year or _____, whichever is sooner. I may terminate this authorization in writing at any time. I have a right to a copy of the authorization and may inspect and receive a copy of the disclosed or used information.

Parent Signature _____ Date _____ Student Signature * _____ Date _____

* If the student is a minor but is authorized to consent to health care without parental consent under federal and state laws, only the student shall sign this form.

HIV/AIDS, STDs status, diagnosis, treatment	14 years of age
Family Planning/Abortion	No age limit
Alcohol/Drug Treatment	13 years of age
Mental Health Services	13 years of age

(Envelope shall be marked "**CONFIDENTIAL**")