OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Oakland Unified School District
Health Services Department

Health Insurance Portability and Accountability Act (HIPAA)
Authorization to Release Medical Information

A. STUDENT/PATIENT INFORMATION

Student Name (Last, First, Middle): ____

Date of Birth: ____________________ Sex: ☐ M ☐ F Permanent Student ID #: ______________________

B. INFORMATION TO BE RELEASED FROM (√ as needed):

☐ ________________________ School District

☐ Healthcare Provider/Clinic/Other: ________________________________

Phone number: ______________ Medical Record #: ____________________

☐ Healthcare Provider/Clinic/Other: ________________________________

Phone number: ______________ Medical Record #: ____________________

___ Endocrinology
___ Gastroenterology
___ Neurology
___ PT/OT
___ Pediatrics
___ Rehabilitation
___ Speech & Hearing
___ Special Clinics
___ Other__________

C. INFORMATION TO BE RELEASED TO AND USED BY OUSD

School/Department: ________________________________Contact person: _OUSD School Nurse_____

Address: ______________________________ City: ______________ State: ______ Zip Code: ________

Phone: ______________________________ Fax: ________________________________

D. PURPOSE OF THE REQUESTED INFORMATION

☐ Assist in determining most appropriate school education program/learning accommodations
☐ Assist in providing medical care during the school day
☐ School Enrollment
☐ Other: ____

E. TYPE/DESCRIPTION OF INFORMATION REQUESTED

☐ Immunization Record
☐ Physicians Orders
☐ History and Physical/CHDP
☐ Healthcare Provider's Report
☐ Lab Results/X-ray Reports
☐ Mental Health Records
☐ ________________Action Plan
☐ Appointment Dates/Times
☐ Diabetes Management Plan
☐ Other: ____

F. SIGNATURE AUTHORIZING RELEASE OF INFORMATION

By signing below, I understand that the information released may include information regarding treatment, hospitalization, or outpatient care, including psychological/psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV tests, and gives the requester permission to communicate with the health care provider, unless otherwise excluded here:

____

I also understand that the school district is responsible for maintaining confidential files for access and review only by involved educational staff. Academic, psychological, and health records are exchanged among California public schools.
I have read and understand the "Authorization Restrictions and Rights" on the backside of this form.
Unless revoked, this authorization will expire in 1 year, unless otherwise specified here:

____

APPROVAL: ______________________________ ______________________________
Printed Name Signature

______________________________ ______________________________ ______________
Relationship to Patient/Student Area Code and Phone Number Date

If you have additional questions contact HealthServices@ousd.org | www.ousd.org

AUTHORIZATION RESTRICTIONS AND RIGHTS

- Signing this authorization is voluntary. You can refuse to sign this authorization. Refusing to sign this authorization will not affect Oakland Unified School District's commitment to providing a quality education for your child. However, refusing to sign may inhibit the school's ability to implement an optimal plan of education, learning accommodations and/or health care plan for your child.

- This authorization may be changed at any time. To change this authorization, you must provide the organization or individual, listed in Section B of this form, with a written request to change the authorization. Any information disclosed before your written request to change the authorization is received may be used as previously permitted.

- You have the right to receive a copy of this document [Health Insurance Portability and Accountability Act (HIPAA)]. If you request it, you will receive a copy of this document after you sign it.

- Oakland Unified School District is responsible for maintaining confidential files for access and review by involving educational staff only. Academic, psychological, and health information are exchanged among California public schools. No further disclosure of this information by Oakland Unified School District should be done without specific written and informed release by a parent or legal guardian.

- If you authorize disclosure of information to a person that is not legally required to keep it confidential, the information may be re-disclosed and may no longer be protected by state or federal law.

- You may inspect or copy the information to be disclosed, as provided in CFR 164.524.

Documents adapted from the California School Nurses Organization generic form, 2004.