Okemos School District Request for Protected Information (Health)

Child Information

Child's Name:	Date of Birth:
Parent's/Guardian's Name:	

Purpose

The purpose of this request is to collect information necessary to provide SCHOOL DISTRICT services to your child.

Medical Provider(s) Authorized to Share Information with School District

The medical provider(s) listed below have permission to share the specific information listed about my child.

Medical Provider:	Specific information to be shared with School District:
Medical Provider:	Specific information to be shared with School District:

Authorization

My signature below means I understand that:

√ My authorization to allow the sharing of information about my child is voluntary and expires at the end of the school year.

√ Information regarding behavioral and mental health services or communicable diseases, such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Deficiency Syndrome or AIDS related complex) may be shared if I initial here _____ or if I list this type of information above.

√ Information received under this authorization becomes part of the child's educational record, and is protected by Family Educational Rights and Privacy (FERPA), and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

√ Information may be re-disclosed by SCHOOL DISTRICT as part of the educational record and protected by FERPA.

√ I may refuse to sign this authorization.

- Refusal to sign may affect the ability of SCHOOL DISTRICT to obtain information necessary to provide SCHOOL DISTRICT services to my child.
- Refusal to sign this authorization will not affect my ability to obtain SCHOOL DISTRICT services. However, the information obtained can help provide services that are individualized for my child.

√ I may revoke or cancel consent at any time, without penalty, by notifying SCHOOL DISTRICT in writing. Information that has already been shared based on this authorization cannot be taken back.

I have read and understand this authorization form (or it has been read to me in a language I understand)

☐ and:

I authorize the above listed medical provider or designee to engage in verbal, written, and/or electronic communication in order to share specified records and information.

☐ OR

I do not wish to have any information released at this time.

Signature of Parent/Guardian:	Relationship to Child:	Date: