WORCESTER PUBLIC SCHOOLS
DEPARTMENT OF NURSING

HIPAA-Compliant Authorization for Exchange of Health Information

Patient/Student Name:_____**Date of Birth:**_____

I hereby authorize_____(insert health care provider name & title)

and_____School Nurse/School Physician to exchange health

information/records for the purpose listed below.

_____(insert address & telephone of school/school district)

_____(insert address and telephone of health care provider)

Description:

The health information to be disclosed consists of:

1. Immunizations
2. Telephone conversations
3. Medical information that is needed to care for the student in school
4. Past or current medical conditions and the impact it may have on attendance, athletics, school programming, or therapy(ies).
5. Other:_____

Purpose: This information will be used for the following purpose(s):

- □ Educational evaluation and program planning
- □ Health assessment and planning for health care services and treatment in school
- □ Medical evaluation and treatment
- □ Other:_____

Authorization

This authorization is valid for one calendar year. It will expire on _____(insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____

Parent Signature Date

_____

Student Signature Date

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School Nurse requesting/receiving the protected health information