SUWANNEE COUNTY SCHOOL DISTRICT

Office of Student Services
1740 Ohio Avenue, South
Live Oak, Florida 32064
386-647-4630

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

Patient/Student Name:
First, Middle Initial, Last _____ **Date of Birth:** _____

I, the undersigned, do hereby authorize *(name of agency and/or health care providers)*:

(1) _____ **(2)** _____

to provide health information from the above-named child's medical record to and from:

School District to which Disclosure is Made	***Address/City and State/Zip Code***
Contact Person at School District	***Area Code and Telephone Number***

The disclosure of health information is required for the following purposes:

Requested information of health information is required for the following purpose:

Requested information shall be limited to the following: ☐ *All minimum necessary health information; or* ☐ *Disease-specific information as described:*

DURATION: This authorization shall become effective immediately and shall remain in effect until_____ *(enter date)* or for one year from the date of signature, if no date entered.

RESTRICTIONS: Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization from from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS: I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE: I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

Printed Name	***Signature***	***Date***
Relationship to Patient/Student	***Area Code and Telephone Number***	