Clarksville Montgomery County School System
HEALTH SERVICES
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 the information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____/_____
Last First MI DOB

I, the undersigned, do hereby authorize (name of agency and/or health care providers):
(1)_____ (2) _____

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

_____ _____
School District/School Name (Requestor) Address/city and state/zip

_____ _____
Contact person at school Area code with phone number

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

_____

Requested information shall be limited to the following:
[ ] All minimum necessary health information
[ ] Disease-specific information as described: _____
(If neither box is checked, no limit applies, and all health information will be disclosed)

DURATION: This authorization shall become effective immediately and shall remain in effect until: _____
Effective 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 form 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 any time. 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 (CMCSS) 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 education record. The information may be shared with individuals working at or with the School District with legitimate educational interest in order to provide safe, appropriate, and least restrictive educational settings and school health services and programs.

This is an authorization for release of documents and does____ /does not ____ permit verbal discussion of the records.

I have the 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.

A photocopy of this Authorization is effective and valid as the original.

APPROVAL

Printed Name: _____ Relationship to Student: _____
Phone Number: ( ) _____
Signature: _____ Date: _____