AUTHORIZATION FOR EXCHANGE OF HEALTH INFORMATION

Student Name: ______________________ Birthdate: __________

I hearby authorize ________________ (Health Care Provider) and _______________________________ (School District or School Employee) health information/records for educational evaluation and planning, or medical evaluation and treatment.

This authorization is valid for one calendar year. 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.

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Parent/Guardian Signature Date