

## Authorization for Release And Use of Health Information

Student \_\_\_\_\_

Birth Date \_\_\_\_\_

I authorize the release of the above-named student's health information (as designated below)

**From** \_\_\_\_\_ **To (District/School): Jordan School District**  
 Address: \_\_\_\_\_ Attention (Contact Person): \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

The released information will be used for the following purposes (please **check** all that apply):

<input type="checkbox"/> Educational <input type="checkbox"/> Legal	<input type="checkbox"/> Medical <input type="checkbox"/> Other	<input type="checkbox"/> Personal
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Specific information to be released (please **initial** all that apply for treatment dates \_\_\_\_\_ to \_\_\_\_\_).

<input type="checkbox"/> Complete Records	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Physical/Occupational Therapy Records	<input type="checkbox"/> Special Education Records
<input type="checkbox"/> Psychological Reports	<input type="checkbox"/> Intervention Summaries	<input type="checkbox"/> Assessment Results
<input type="checkbox"/> Mental Health Reports	<input type="checkbox"/> Speech/Language Reports	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Two-way Communication	<input type="checkbox"/> Other _____	

This authorization shall remain in effect for six (6) months from the date of signing. I understand that I have the right to revoke this authorization to the school and student's physician on behalf of my minor child by providing written notice to the health care provider consistent with the health care provider's policies. Revocation does not affect releases of medical records made prior to the revocation.

I understand that the health care provider is not responsible for any further disclosures of the released information by the school/district. I also understand that the released medical records may become part of the student's education records and may be forwarded to another school in which the student seeks or intends to enroll. The school and district will protect this information in compliance with the Family Educational Rights and Privacy Act (FERPA).

Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records may be required in order for the school to implement an appropriate plan of education, learning accommodations/modifications, and or health care.

I understand that if I authorize release of the above information to any individual or entity that is not legally required to keep it confidential, the information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996, or any other state or federal law.

By my signature below, I authorize the release and use of the information in accordance with the rights, restrictions and understandings above.

\_\_\_\_\_  
 Signature of Parent/Legal Guardian/Student at Age of Majority

\_\_\_\_\_  
 Date

Authorization Expires \_\_\_\_\_

Copy to Parent(s) \_\_\_\_\_