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.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: Last First MI _____ Date of Birth _____

I, the undersigned, recognize that my child's health records are covered by FERPA and do hereby authorize:

Healthcare Provider (Name) _____ Phone: _____

Address _____

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

The Long Beach Island School District / Student Health Services

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

To assist the student in maintaining optimum health and safety in the school setting.

Requested information shall be limited to the following:

- ❑ All minimum necessary health information necessary to complete, maintain and update the student's health record **or**
- ❑ Disease-specific information as described: _____

DURATION:
This authorization shall become effective immediately and shall remain in effect for the school year and updated annually.

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 (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:

Name (Printed) _____

Signature _____ Date _____

Relationship to Patient/Student _____ Phone _____