Toledo Public Schools

Fax # 419-671-_____

HIPAA-Compliant Authorization for Release of Health and Education Information

Patient/Student Name _____ Date of Birth _____

I hereby authorize _____
(Health care provider name and title)

_____
(Health care provider **address**) (Health care provider **telephone** number) (Health care provider **fax** number) and _____(name & title of school official) to exchange health and education _____(address & telephone of school/school district)

Information/records for the purpose listed below.

Dear Health Care Provider:

The information to be disclosed consists of the following (within the past twelve months):
Evaluations, standardized test results, psychology evaluations, pediatric consultations, observational data, allergies, medical information and/or diagnosis.
This information will be used for the following purpose(s):

1. **Health assessment and planning for health care services and treatment in school.**
2. **I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.**
3. **Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient.**
4. **The information in my health record may include information relating to sexually transmitted disease, TB, hepatitis B, AIDS, HIV. It may include information about behavioral or mental health services and treatment for alcohol & drug abuse.**
5. **Other _____**

Authorization

This authorization is valid for one calendar year. It will expire on _____ (date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA 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.

_____

Parent/Guardian Signature **Date**

Copies to: Parent/Guardian
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

Revised
9/8/15