**STUDENT HEALTH INFORMATION**

**AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION AND EDUCATION RECORDS**

Student's Name: _____ Date of Birth: _____ **MR#** *(Staff to Complete):* _____

**Phone:** _____ **Address:** _____

**USE AND DISCLOSE MEDICAL AND / OR EDUCATION RECORDS BETWEEN:**

| | |
|---|---|
| Facility or Name: _____ | District Name _____ |
| Address: _____ | School Name: _____ |
| City/ST/Zip: _____ | Address: _____ |
| Phone #: _____ | Phone #: _____ |
| | Fax #: _____ |

## Authorization

1. I authorize the school nurse and Nemours medical personnel to discuss and share educational records and health information.
2. I understand the school nurse will have access to both treatment and non-treatment related information in my child's medical record.
3. I may revoke this authorization at any time by providing written notification to the addresses listed above for Nemours and my school.
4. I understand that my revocation does not affect any disclosures made prior to the revocation being received and processed.
5. I understand that signing this authorization is strictly voluntary.
6. I can request a copy of this form after I sign it.

**EXPIRATION DATE:** This authorization will expire at the completion of the current school year _____ unless an earlier date is specified: _____

Patient/Guardian/ Representative Signature: _____ Date: _____

Patient/Guardian/ Representative Printed Name: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

* Parent or eligible student as required and defined by Family Education and Privacy Rights Act (FERPA)

*FAX completed form to:*