Muscogee County School District
Student Health Services
HIPAA Compliant Release of Information
Authorization to Release Protected Health Information

Student's Full Name (print)	Student's date of birth
Parent/Guardian's Name (print)	Daytime Phone number

Physician or healthcare facility records requested from:

_____ Phone: _____
_____ Fax: _____
_____
_____

Send requested health record information to:
{INSERT SCHOOL NURSE NAME}, RN
{INSERT SCHOOL NAME}
{INSERT SCHOOL ADDRESS}
COLUMBUS,GA {INSERT SCHOOL ZIP CODE}
Phone: {INSERT RN PHONE NUMBER}
Fax: {INSERT SCHOOL FAX NUMBER}

The following information is to be released (check all that apply):

- □ Physician's Orders
- □ Discharge Summary/Instructions
- □ Emergency Room Record
- □ Special Procedure
- □ Neuropsychological
- □ Records from:_____
- □ Other:_____
- □ Activity Restrictions
- □ Allergy Information
- □ Student Health Care Plan
- □ Physician's Office Notes
- □ Immunization Record
- □ Current Medications and Dosage

I authorize the above provider and school nurse to exchange health information/records for the purposes of educational evaluation and program planning, health assessment and planning for health care services/treatments in school, and medical evaluation and treatment. I understand that any information released may be shared with school administration, teachers, school nurses, school clinic worker, cafeteria staff, and other school employees, as necessary. **Additionally, I understand that is my responsibility to notify the school bus driver of any and all health conditions for my child in person, via written note, or by contacting the Transportation Supervisor at 706-748-6985.**

I understand that I have the right to revoke this authorization in writing at any time. I understand that any revocation will not apply to information that has already been released in response to this authorization. I recognize that health records, once received by the school may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. Further, I understand that this authorization applies to both verbal and written exchange of information.

This authorization is valid for one year and will expire on: _____.

Parent/ Guardian Signature	Date