HIPAA COMPLIANT RELEASE OF INFORMATION FORM
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_______________________________________ ____________________________
Print Student's Full Name — Student's Date of Birth

_______________________________________ ____________________________
Print Name of Parent/Guardian — Date

Physician, Healthcare Facility, or School records requested from:

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Applicable Dates and Encounters: ____

The following information is to be released:

____ Doctors Order
____ Emergency Room Record
____ Specialists Reports
____ PE/Activity Restrictions
____ School Plans (IEP/504)
____ Immunization Records
____Other ____________________________

The purpose of this request is to continue appropriate health care in the school. Medical Records received will become part of the student's educational records. These records will move from school to school with the student. The school nurse and/or other school employee designees will review these records.

This authorization expires in 12 months or ____________________________.

Send requested health information to:

Megan D. Steele, MSN, RN
School Nurse
3905 Green Valley Road
Phone: 785-776-2223
Fax: 785-776-3016
E-Mail: nurse@fhcsks.org

I understand I have the right to revoke this authorization in writing at any time.

_______________________________________ ____________________________
Signature of Parent/Guardian — Date