

## COUNTY PUBLIC SCHOOLS

Sample Student Record Release Form (To Be Completed by Parent or Guardian)

HIPAA – Compliant Authorization for Exchange / Release of Immunizations / Health / Education Information

<b>Patient/Student's Name:</b> _____ <b>D.O.B.:</b> _____	
<b>Written*</b>	<i>Written exchange of information relevant to reason for this request.</i> I hereby authorize _____ (insert name, title, address, and telephone number) to release my/my child's health/immunization or education information, records, or documents for the purpose(s) listed below to _____ (insert name, title, address, and telephone number)
	<i>Verbal exchange of information relevant to reason for this request.</i> I hereby authorize _____ (insert name, title, address, and telephone number) and _____ (insert name, title, address, and telephone number) to verbally exchange my/my child's health/immunization and education information/records for the purpose(s) listed

\* Information will be communicated only via the completed box(s) above.

### Description:

The information to be disclosed consists of:

- Immunizations as Required by Annotated Code of Maryland, Educ §7-403
- Medication Order
- Treatment Order
- Other Medical Records \_\_\_\_\_
- Special Education Records
- Psychological/Psychiatric Evaluation
- Official School Records

### Purpose:

This information will be used for the following purpose(s):

- Admission to School
- Educational Evaluation and Program Planning
- Other \_\_\_\_\_
- Medical Evaluation and Treatment
- Health Assessment and Planning for Health Care Services and Diagnosis in School

### Authorization:

I, (name of parent or guardian) \_\_\_\_\_, authorize the disclosure of the above specified health/immunization and educational records to the individuals affiliated with the school as indicated above. I understand that, if the persons or organizations I authorize to receive and/or use the immunization records are not subject to the federal or state health information privacy laws, they may further disclose the immunization records, in which case, it may no longer be protected by the health information privacy laws.

This authorization is valid for one calendar year. It will expire on \_\_\_\_\_ (insert 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 Rule, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA) and become part of the student's cumulative record. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

\_\_\_\_\_  
**Parent's/Guardian's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name Printed, Address and Telephone Number**

\_\_\_\_\_  
**Student's Signature\***

\_\_\_\_\_  
**Date**

\* If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Maryland, a competent minor, depending on age, can consent to outpatient mental health care, drug and alcohol abuse treatment, testing for HIV/AIDS, and reproductive health care services.

White Copy: Parent or student\*