STUDENT HEALTH, WELLNESS & PREVENTION

AUTHORIZATION FOR EXCHANGE OF HEALTH INFORMATION WITH TWIN RIVERS UNFIED SCHOOL DISTRICT

I authorize: _____

School Site / School Nurse

_____

Street Address City State Zip Code

_____

Phone Fax Email

To exchange health information to and from:

_____

Name / Title of facility and contact person (Doctor's name)

_____

Street Address City State Zip Code

_____

Phone Fax Email

Regarding: _____

Student name, Date of Birth and Record number if available

Type of health information: _____

Date(s) of treatment: _____

I specifically request the exchange of the following information:

☐ Immunizations ☐ Medical ☐ Mental Health
☐ Drug / Alcohol ☐ HIV Results ☐ Medication

You may also authorize the release of information for treatment provided after the date of the signature on this authorization as long as the treatment occurs while this authorization has not expired. Please initial if you would like this authorization to release information about healthcare you received after the date of your signature. _____

Duration: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here _____ (date).

Revocation: You or your representative may revoke this authorization at any time upon written request to either provider. If you revoke authorization it will take effect when received. It will not affect information disclosed before receipt of the written request.

Re-disclosure: Once health information is disclosed it may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA). The confidentiality of the information when released to a public school is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.

_____ _____ _____

Signature of Student's Representative Relationship to Student Date