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: **Nemours/Alfred I. duPont Hospital for Children**	District Name:
Address: **1600 Rockland Road**	School Name:
City/ST/Zip: **Wilmington, DE 19899**	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 (August 15), 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: 1- 800-428-9768