Hilliard City School District · 2140 Atlas St · Columbus OH 43228

Authorization to Disclose Health Information

Student Name:_____ Student ID#_____

Student Address:_____ Date of Birth:_____

I, _____, as the parent/guardian of the above-named child, hereby authorize *(Name of Provider)*_____

*(Address of Provider)*_____

*(Phone Number of Provider)*_____

to disclose the specific and individually identifiable health information of the above-named child to the following authorized person(s) or entity(s):_____

_____

Information to be disclosed: Describe the personal health information you are authorizing to be provided or received:

_____

_____

Purpose of disclosure: This disclosure is requested for the following reason(s):_____

_____

_____

I have read and understand the following statement about my rights:

- I may revoke this authorization, in writing, at any time and may be asked to sign the revocation section on the back of this form.
- Any action taken by the above-named Provider(s) or School in accordance with this authorization prior to it being revoked is legal and binding.
- If not revoked, this authorization will expire one (1) year after the date on which it was signed.
- This information may not be protected from re-disclosure by the requestor of information unless otherwise provided for by state or federal law. Please note: medical records provided to schools that receive federal funding are protected by the Family Educational Rights and Privacy Act (FERPA).
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.
- My refusal to sign this authorization, if required to obtain immunization records, may prevent the school from verifying that my child has been immunized. If the school cannot verify and I cannot provide satisfactory written evidence of immunization, my child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.
- I may request a copy of this signed authorization for my own records.

Signature of Parent/Guardian:_____ Date:_____

NOTE: This authorization was revoked on:_____ _____

Date Signature of Staff

Authorization to Disclose Health Information

Revocation Section

I do hereby request that this authorization to disclose the health records of my child,

_____, signed by _____ on
(Student's Name) *(Person Who Signed Authorization)*

_____ be revoked, effective _____.
(Date Signed) *(Date Revoked)*

I understand that any action taken by the named Provider(s) or School in accordance to this authorization prior to the date of revocation is legal and binding.

Signature of Parent/Guardian:_____ Date:_____

Signature of Witness:_____ Date:_____