Mike Oberhaus, Ed.D
Superintendent

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations require us to keep students' protected health information confidential.

This authorization is voluntary. I, as parent/guardian, understand that enrollment, or eligibility for or receipt of educational services may not be conditioned on signing this authorization. I further understand that I have the right to revoke this authorization at any time and that the revocation must be in writing. Revocation will take effect upon receipt by the Office of the Principal. I am also entitled to a copy of this authorization.

Authorization
I authorize school nurses, social workers, speech therapists, psychologists, and other providers of educational services to release health information to other School District personnel as may be necessary and appropriate to provide educational services to my child.

Expiration
This authorization expires at the end of my child's enrollment in the Rock Island-Milan School District.

WARNING I understand that once protected health information is disclosed pursuant to this authorization, there is a risk that the person to whom disclosure is authorized may re-disclose it.

I, as parent/guardian, sign this authorization voluntarily.

_____

Print parent/guardian's name **and** child's name

_____ _____

Signature Date

Rock Island-Milan School District #41
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