CENTRAL VALLEY
SCHOOL DISTRICT #356

AUTHORIZATION FOR *RELEASE* OF HEALTH CARE INFORMATION

Patient Name _____ Birthdate _____

I authorize the release of the healthcare information described below to be released from and sent to the following:

Information to be released FROM: _____
Name of facility or provider

Information to be released TO: _____
Name(s) of recipient(s)

_____
Address

_____
City, State, Zip Code

_____
Phone

Specific information to be released: _____
_____
_____

Purpose for which disclosure is being made: _____
_____
_____

Specific Minor Patient Authorization:
If the patient has reached the age below, only the patient can authorize disclosure relating to the following:

- ☐ HIV/AIDS, STDs status, diagnosis, treatment (consent may be given by student 14 years of age)
- ☐ Family planning/abortion (consent may be given by any age student)
- ☐ Alcohol/drug treatment (consent may be given by student 13 years of age)
- ☐ Mental health services (consent may be given by student 13 years of age)

My Rights

I understand I have a right to request and receive a Notice of Privacy Practices. I may inspect and receive a copy (a nominal fee may be charged). Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing the authorization.

I may revoke this authorization in writing by presenting it as provided in the Notice of Privacy Practices for the Facility, but the revocation will not apply to information already used or disclosed. I recognize that this information, once received by the school district, may no longer be protected by the HIPAA Privacy Rule and become educational records protected by the Family Education Rights and Privacy Act (FERPA), but will be handled in compliance with applicable state and federal laws and school district policies and procedures. The provider must make the healthcare information available within 15 working days after receiving the request or notify the patient of any delay (RCW 70.02.080).

Expiration: I understand this authorization will expire at the end of the current school year.

_____ _____
Signature of patient/legal representative Date

_____ _____
Relationship to Patient Phone number

Copies: Agency/person
Nurse
Parent/guardian

Revised 2/2012