HIPAA Authorization for School Health Records

Student Information

Student Name

Date of Birth

School Name

Parent/Guardian Information

Name

Relationship to Student

Health Provider Releasing Records

Provider/Facility Name

Provider Address

Provider Phone

Information to be Released

Purpose of Disclosure

Recipient

Individual/Organization Receiving the Information

Recipient Address

Authorization Details

This authorization expires on

Other Conditions (if any)

Signature

Signature of Parent/Guardian

Date