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)