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Oak Harbor Public Schools
Authorization for Release of Protected Health Information

Student: _____ Birth Date: _____ Grade: _____

School: _____ Student/ID No: _____

I authorize disclosure of protected health information only in the specific manner(s), for the named reason(s), and to the specific individual(s) as described in this form.

1. I understand that information obtained by the Oak Harbor School District will be treated in a confidential manner under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Protected health information received by the District is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

2. I understand that, if a recipient of the information disclosed under this authorization is not the Oak Harbor School District and is not a health plan or provider covered by HIPAA, the information may be re-disclosed by the recipient and may no longer be protected by federal and state HIPAA laws. If the information being disclosed under this authorization relates to HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol diagnosis, treatment, or referral information, federal or state law may prevent the recipient from re-disclosing the information.

3. I understand that if a health care provider is being asked to provide protected health information, that health care provider may not condition continuing treatment on whether or not I sign this authorization.

4. I understand that my consent for the release of protected health information is voluntary, and I can withdraw my consent at any time in writing. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

5. I understand that this authorization may include disclosure of protected health information related to treatment for alcohol/drugs, family planning/abortion, HIV/AIDS, and mental health only if I place my initials on the appropriate line(s) in Item 8.

6. Entity (e.g., health care provider) to release health information:

   Name: _____

   Phone: _____ Fax: _____

   Name: _____

   Phone: _____ Fax: _____

   Name: _____

   Phone: _____ Fax: _____

7. Individual(s) or category of individuals to whom this health information will be released:

   Name: _____ Name: _____

   Name: _____ Name: _____

Student Name: _____ DOB: _____

8. Specific information to be released:

   ☐ Health care information from the following dates of treatment: _____to_____

   ☐ Other health care information (specify): _____

   Information to be released shall include the following, if initialed or checked:

   ____ Alcohol/drug treatment information (*student's consent required if 13 years of age*)

   ____ Family planning/abortion information (*student's consent required*)

   ____ HIV/AIDS-related information (*student's consent required if 14 years of age*)

   ____ Mental health information (*student's consent required if 13 years of age*)

9. Purpose for release of information:

   ☐ At the request of an individual: ☐ Educational Planning:

   ☐ Other: _____

Contact Information for Parent/Guardian/Adult Student

Name: _____

Relationship to student (*if not adult student*): _____

Address: _____ Phone: _____

This authorization expires on _____ (*insert date*) or upon occurrence of the following event that relates to me or the purpose of this authorization: _____.

If this form does not contain an expiration date, it expires 90 days from the signature date below.

All items on this form have been completed and my questions about this form have been answered. <u>Additionally, I have been provided a copy of this authorization form</u>.

_____ _____

Signature of parent/guardian/adult student Date

_____ _____

Signature of student over 13 years of age (*if necessary*) Date