Outpatient Medical Center Inc. School Based Health Center

HIPAA-Compliant Authorization for Exchange of Health & Education Information

Patient/Student Name: _____**Date of Birth:** _____

I hereby authorize the staff of the SBHC and the school nurses and principals of the school to exchange health and education information/records for the purpose listed below.

OMC School Based Health Clinic, 1500 Gold St. Natchitoches, LA 71457, 318-238-7440

L.P. Vaughn Elementary School, 1500 Gold St. Natchitoches, LA 71457, 318-352-2369

Description:
The health information to be disclosed consists of medical records.

The education information to be disclosed consists of student schedule, demographics, and any health information obtained by school.

Purpose: This information will be used for the following purpose(s):
1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school.
3. Medical evaluation and treatment
4. Other**:**_____

Authorization

This authorization is valid for one calendar year. It will expire on June 1, 2020. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____

Parent Signature Date

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information PSA - Rev. 4/15/03