HERMITAGE SCHOOL DISTRICT
AUTHORIZATION TO RELEASE/OBTAIN SCHOOL RECORDS AND/OR HEALTH INFORMATION

STUDENT'S NAME: _____
LAST **FIRST** **MIDDLE**

BIRTH DATE (DATE-MONTH- YEAR) _____ **CURRENT GRADE OR YEAR GRADUATED** _____

I hereby authorize the Hermitage School District to release to/obtain from (circle one) the School/Physician/Provider noted below, any appropriate information or records they have on the above named student. This information is to be used only for professional purposes and will be treated in a confidential manner in compliance with the Family Educational Right to Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA).

Former School/Physician/Provider Name: _____

Former School/Physician/Provider Address: _____

_____

Former School/Physician/Provider Telephone Number: _____ **Fax Number:**_____

Documents/Information to Be Released:

- ❑ **ALL ITEMS LISTED BELOW**
- ❑ **CUMULATIVE RECORDS: including grades, test scores and last date of attendance.**
- ❑ **HEALTH RECORDS; INCLUDING IMMUNIZATION RECORD**
- ❑ **INFORMATION ON SPECIAL NEEDS: If the student is in a SPECIAL EDUCATION PROGRAM, Evaluation Reports, Notice of Recommended Educational Placement (NOREP), Individualized Education Program (IEP), Gifted Individualized Education Plan (GIEP), Notice of Recommended Assignment (NORA)**
- ❑ **Other:** _____

Note: This authorization will permit disclosure of relevant Mental Health Information or Alcohol/Substance Abuse Treatment; however, does <u>not</u> include permission to disclose HIV/AIDS.

Purpose of Disclosure (explain or indicate "at the request of the individual"): ___

_____

_____

REGARDING HEALTH INFORMATION:

- I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that I have the right to revoke this Authorization, at any time prior to the Hermitage School District's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Hermitage School District's Notice of Privacy Practices I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to: Hermitage School District, Central Administration Office, 411 North Hermitage Road, Hermitage, Pennsylvania 16148, Attention: Monique Barber – Privacy Officer
- I understand that I am not required to sign this Authorization and that the Hermitage School District may not condition treatment on my execution of this Authorization.
- I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This Authorization expires upon the Hermitage School District's release of the information described above or 90 days after the Date of Authorization, as set forth below, whichever comes first.

I hereby acknowledge receipt of a copy of this Authorization.

_____ _____
PRINT NAME **SIGNATURE OF PARENT/GUARDIAN OR EMANCIPATED STUDENT**

_____ _____
DATE **RELATIONSHIP TO STUDENT**

FOR OFFICE USE ONLY: DATE RECORDS SENT/RECEIVED: _____

4/2018