Urbana School District #116
1101 E. University Avenue, Suite B, Urbana IL 61802
217-384-3600

Authorization for Use and Disclosure of Protected Health Information and Education Records

Patient/Student Name: ____ **Date of Birth:** ______________________

I hereby authorize: ______________________________________
____
____

to disclose protected health information and/or educational records to:

____
____
____

_____ Check here if authorization is given for the parties listed above to mutually exchange the information described below.

Description:
The health information to be disclosed consists of (check all that apply):

_____ Any and all records in the possession of __________________________ including mental health, HIV and/or substance abuse records. (Cross out any item that you do not authorize to be released)
_____ Records regarding treatment for the following condition or injury __________________________
_____ Records covering the period of time between ____________________ and ____________________
_____ Other (be specific, including dates) ____

The education information to be disclosed consists of (check all that apply):

_____ Any and all educational records, including special education records
_____ Records covering the period of time between ____________________ and ____________________
_____ Other ____

Purpose: This information is to be disclosed at the individual's request and will be used for the following purpose(s) (check all that apply)

_____ Educational evaluation and program planning
_____ Health assessment and planning for health care services and treatment in school
_____ Medical evaluation and treatment
_____ Other ____

This authorization is valid for one calendar year and will expire on ____________________. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. 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. I also understand that I have the right to inspect and copy educational records and to challenge their contents.

Parent Signature ____ Date _______________

Student Signature* ____ Date _______________

*student signature required if the minor student is over age 12 and if this authorization is for the release of mental health records