ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services

STUDENT RECORD RELEASE

(To Be Completed by Parents/Legal Guardians)

HIPAA – Compliant Authorization for Exchange / Release of Immunizations / Health / Education Information

Patient/Student's Name: _____ D.O.B.: _____

Written*

Written exchange of information relevant to reason for this request.

I hereby authorize _____

(insert name, title, address, and telephone number)

to release my child's health/immunization or education information, records, or documents for the purpose(s) listed below to

_____

(insert name, title, address, and telephone number)

Verbal*

Verbal exchange of information relevant to reason for this request.

I hereby authorize _____

(insert name, title, address, and telephone number)

and _____

(insert name, title, address, and telephone number)

to verbally exchange my child's health/immunization and education information/records for the purpose(s) listed below:

* Information will be communicated only via the completed box(s) above.

Description:

The information to be disclosed consists of:

- ☐ Immunizations as Required by Annotated Code of Maryland, Educ §7-403
- ☐ Medication Order
- ☐ Treatment Order
- ☐ Other Medical Records _____
- ☐ Special Education Records
- ☐ Psychological/Psychiatric Evaluation
- ☐ Official School Records

Purpose:

This information will be used for the following purpose(s):

- ☐ Admission to School
- ☐ Educational Evaluation and Program Planning
- ☐ Other _____
- ☐ Medical Evaluation and Treatment
- ☐ Health Assessment and Planning for Health Care Services and Diagnosis in School

Authorization:

I, (name of parents/legal guardians) _____, authorize the disclosure of the above specified health/immunization and educational records to the individuals affiliated with the school as indicated above. I understand that, if the persons or organizations I authorize to receive and/or use the immunization records are not subject to the federal or state health information privacy laws, they may further disclose the immunization records, in which case, it may no longer be protected by the health information privacy laws.

This authorization is valid for one calendar year. It will expire on _____ (insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these 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 (FERPA) and become part of the student's cumulative record. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____ _____

Parent's/Legal Guardian's Signature Date

_____

Name Printed, Address and Telephone Number

_____ _____

Student's Signature* Date

* If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Maryland, a competent minor, depending on age, can consent to outpatient mental health care, drug and alcohol abuse treatment, testing for HIV/AIDS, and reproductive health care services.

Copy: Parents/Legal Guardians or student*
Copy: Physician or other health care provider releasing the protected health information
Copy: School official requesting/receiving the protected health information