Trinity Lutheran School
HIPAA-Compliant Authorization for Release of Health Information

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

I hereby authorize _____ to release my child's health information/records for the purpose listed below to:

Teacher, teacher aids (staff with direct contact with my child), bus driver (if applicable)

Description:
The information to be disclosed consists of: pertinent health concerns

Purpose:
This information will be used for the following purpose(s):
Ensure student's health and safety

Authorization

This authorization is valid for as long as my child has health concerns or until such time my child no longer attends Trinity Lutheran School. I understand that I am responsible for notifying Trinity Lutheran School in any changes concerning my child's health. 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. 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

_____ ____/____/____
Student Signature Date