HIPAA Authorization to Use/Disclose PHI

School/Educational Programs and Services

______________________________ ______________________________ ______________________________

Patient (Student) Name **Date of Birth** **Medical Record #**

Section 1: I hereby authorize **Children's Hospital Colorado** to release information, as described below, to:

Name of School or District **to receive** information: ______________________________

Address: ______________________________

Phone number: ______________________________ Fax number: ______________________________

Select all that apply: ☐ School Nurse ☐ Audiology ☐ Child Find ☐ Psychology ☐ Other________________

Purpose: For the use by the school for educational purposes, including IEP and 504 evaluations and reviews.

Section 2: Type of records and dates to be released for educational purposes** ***(please select all that apply)***

☐ Provider Notes & Reports ☐ Immunization Record ☐ Eye Exams ☐ Audiology Tests ☐ Discharge Summaries

☐ Care Plans (specify departments): ______________________________ ☐ Other: ______________________________

Dates of Services (between): ______________________________ **and** ______________________________

****Please Note:** The information to be released may include *a diagnosis or reference to* the following condition(s): behavioral health services/psychiatric care, sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); drug and/or alcohol abuse, or sexually transmitted diseases. Children's Colorado **will not release these department specific records:** Reproductive health, including pregnancy and sexually transmitted disease, HIV/AIDS, drug/alcohol treatment information, or behavioral health or psychiatric care information.

Section 3: Method of release ***(please select all that apply)***

☐ **Verbal** disclosure between provider and school ☐ School Personnel access/release through **EpicCare Link**

☐ Children's Hospital Colorado Health Information Management/Medical Records needs to process records to **send** to school:

☐ Paper ☐ CD *(only available for records stored electronically)*

☐ Mail to: ______________________________ ☐ Fax to: ______________________________

______________________________ Attn: ______________________________

I understand the following: This authorization will instantly **run out** (expire) on September 30th of each year **or** the date the patient/student becomes an adult under state law. I can ask for an expiration date sooner in writing. I may take back this authorization at any time by telling Children's Hospital Colorado in writing. I understand this would only apply to future releases of information and not information that has been already released. Information that has been released may no longer be protected by HIPAA and may be **re-disclosed**. Once the school gets this information, it may be protected by other law, such as FERPA. Children's Hospital Colorado will still give care and seek payment for care given to my child even if I do not sign this authorization. There will be no charge for copies of medical records provided directly to the school.

This authorization does not apply to information about the treatment relationship between Children's Hospital Colorado and the school personnel. I understand that information will still be shared with the school personnel for care purposes even if I don't sign this authorization.

______________________________ ________________

Signature of Authorized Representative **Date**

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Place Patient Identification Label Here