



STUDENT HEALTH INFORMATION
AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION AND EDUCATION RECORDS

Student's Name: _____
Phone: _____

Date of Birth: _____
Address: _____

MR#
(Staff to Complete):

USE AND DISCLOSE MEDICAL AND / OR EDUCATION RECORDS BETWEEN:

Facility or Name: Nemours/Alfred I. duPont Hospital for Children	District Name: _____
Address: 1600 Rockland Road	School Name: _____
City/ST/Zip: Wilmington, DE 19899	Address: _____
Phone #: _____	Phone #: _____
	Fax #: _____

Authorization

1. I authorize the school nurse and Nemours medical personnel to discuss and share educational records and health information.
2. I understand the school nurse will have access to both treatment and non-treatment related information in my child's medical record.
3. I may revoke this authorization at any time by providing written notification to the addresses listed above for Nemours and my school.
4. I understand that my revocation does not affect any disclosures made prior to the revocation being received and processed.
5. I understand that signing this authorization is strictly voluntary.
6. I can request a copy of this form after I sign it.

EXPIRATION DATE: This authorization will expire at the completion of the current school year (August 15), unless an earlier date is specified: _____

Patient/Guardian/ Representative Signature*: _____	Date: _____
Patient/Guardian/ Representative Printed Name: _____	Relationship to Patient: _____
Witness Signature: _____	Date: _____

* Parent or eligible student as required and defined by Family Education and Privacy Rights Act (FERPA)