LINCOLN COUNTY SCHOOL DISTRICT
HAWK POINT • MOSCOW MILLS • TROY

Mark S. Penny, Ed. D.
Superintendent of Schools

Mende Kemper, RN, BSN
District Health Coordinator

AUTHORIZATION AND RELEASE FOR MEDICAL RECORDS

Patient/Student Name: _____ _____
Last **First** **MI** **Date of Birth**

I, the undersigned, do hereby authorize (name of agency and/or health care providers):
(1)_____ **(2)** _____
to provide health information from the above-named child's medical record to and from:

_____ _____
School District to Which Disclosure is Made **Address / City and State / Zip Code**

_____ _____
Contact Person at School District **Telephone Number**

The disclosure of health information is required for the following purposes:

_____

Requested information shall be limited to the following: ____All minimum necessary health information; or
_____ Disease-specific information as described: _____

- I authorize disclosure of confidential health information/records from a hospital, clinic, health care facility, or any other health care provider, and any physician and staff person who has attended, treated, or examined him/her to provide copies of any and all recorded information concerning him/her and/or his/her protected health information, including but not limited to complete copies of all psychiatric reports, therapist's and/or counselor's notes, psychological records, discharge summaries, progress notes, prescriptions, physicals and histories, nurses' notes, or correspondence.
- The purpose of this authorization is for use by employees of the Lincoln Co. R-III School District to maintain health records and educational evaluation and programming.
- I also authorize any health service provider to speak with representatives of the Lincoln Co. R-III School District regarding care, treatment, diagnosis or condition for use in educational evaluation and programming.

I have full knowledge and understand that:

1. By signing this authorization, I am authorizing the release of my confidential health information/records pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to the above-referenced employees of the Lincoln Co. R-III School District.
2. By signing this authorization, I am requesting and allowing the release of my confidential health information/records to employees of the Lincoln Co. R-III School District.
3. By signing this authorization, I understand that there is a potential that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
4. I understand that I can revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it. I understand that any revocation of this authorization must be in writing and must be addressed to **Dr. Mark Penny, Lincoln County R-III School District, 951 W. College St., Troy, MO 63379.**
5. This authorization expires one year after it is signed.

_____ _____
Printed Name Date

_____ _____
Signature Relationship to student