York High School

1 Robert Stevens Drive
YORK, MAINE 03909
207-363-3621

MEGHAN E. WARD
Principal

MICHAEL A. BENNETT
Assistant Principal

PERMISSION TO DISCLOSE RECORDS (HIPAA-COMPLIANT)

I, _____ , parent and/or legal guardian of _____, a minor (DOB _____), hereby give my child's physician, _____, (hereinafter "provider") permission to disclose all records and information in his/her possession to _____ at York High School in York, Maine (hereafter referred to as "the recipient").

This authorization allows the above provider to copy and send records to the recipient and allows the recipient to inspect the records. This authorization also allows the above provider to orally disclose information to the recipient, including but not limited to information contained in records.

This authorization encompasses *all* records pertaining to the minor, including but not limited to correspondence, notes, reports, questionnaires, application forms, contracts, billing records, payment records, insurance records, work samples, discipline records, report cards, teacher grade books (with other students' names redacted), test protocols (questions and answers), test score calculations, any other test records, medical records, health records, counseling records, mental health records, computer data, *and "third party records"* created by any other individuals or organizations. The term "records" includes information recorded, maintained or preserved in *any* medium, including but not limited to printed, handwritten, magnetic, or electronic.

I specifically authorize the release of HIV/AIDS results and/or treatment, where applicable.
I specifically authorize the release of psychiatric records, where applicable.
I specifically authorize the release of alcohol and substance abuse treatment records, where applicable.

Any costs for photocopying these records for the recipient, or for mailing these records to the recipient, shall be at the School District's expense.

Pursuant to HIPAA, the following are specified as part of this authorization:

a. The purpose of disclosure is to help the School Department identify the minor's needs and provide appropriate educational services.

b. This authorization expires one year after the date it is signed.

c. The parent signing this form understands that he or she may revoke this authorization at any time by providing written notification to the recipient or to the providers named above, except to the extent that this authorization has already been relied on.

d. The parent signing this form has been informed that the providers named above may not condition treatment, payment, enrollment, or eligibility for benefits on whether the parent signs this authorization.

e. The parent signing this form has been informed of the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to be no longer protected by HIPAA. However, the federal Family Educational Rights and Privacy Act (FERPA) generally prohibit school districts and their employees and agents from disclosing student records (or information from those records) without prior written parental consent.

Date: _____ By: _____ Parent(s)