

School:

Grade:

Charleston Community Unit School District #1
HIPAA-Compliant Authorization for Release of Health Information

In the spring of 2003, HIPAA set forth certain guidelines to protect the patient's/student's rights for confidentiality. Under these new guidelines we are now required to have written consent in order to obtain the health information required by the Illinois School Code. Without this consent we will be unable to contact your health care provider.

Patient/Student Name:	Date of Birth:
I hereby authorize my physician(s), Coles County Health Department and other health providers to release my/my child's health information/records for the purpose listed below to:	
Please list all health providers' below:	
	<u>CUSD Health Office Staff</u>
	<u>CUSD #1</u>
	<u>1615 W. Lincoln (217) 639-5017</u>

Description: The information to be disclosed consists of: Health issues relevant to educational needs and health requirements according to the Illinois School Code.
Purpose: This information will be used for the following purpose(s): Coordination of student health care.

Authorization	
This authorization is valid for one calendar year. It will expire one year from date signed. 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/Guardian Signature	_____ Date
_____ Student Signature (18 yrs. or older)	_____ Date
_____ Witness Signature	_____ Date