



# STUDENT HEALTH INFORMATION

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

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

MR# \_\_\_\_\_  
(Staff to Complete)

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### USE AND DISCLOSE MEDICAL AND / OR EDUCATION RECORDS BETWEEN:

Facility or Name: <b>Nemours/Alfred I. duPont Hospital for Children</b>	District Name: _____
Address: <b>1600 Rockland Road</b>	School Name: _____
City/ST/Zip: <b>Wilmington, DE 19899</b>	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)