



**Seaman USD #345 Health Services  
Authorization for Exchange of Health and Education Information**

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I hereby authorize: \_\_\_\_\_  
(healthcare provider name & title)

\_\_\_\_\_ (healthcare provider address and phone #)

and \_\_\_\_\_  
(school nurse name) or (school administrator name)

\_\_\_\_\_ (school nurse address & phone) or \_\_\_\_\_ (school administrator address & phone)

to exchange health and education information/records for the purpose(s) listed below.

**The health information to be disclosed consists of:**

History    Diagnosis    Medications    Lab Work    Plan of care for the school day  
 Summary of Treatment    Legal issues/concerns  
 Other (specify) \_\_\_\_\_

This information will be used for the following purpose(s):

Educational evaluation and program planning.  
 Health assessment and planning to ensure safe health care services and treatment in school.  
 Medical evaluation and treatment.  
 Other: \_\_\_\_\_

**Authorization:**

This authorization is valid for one year from date noted below, or as specified \_\_\_\_\_.  
It will expire on \_\_\_\_\_. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may no longer be protected by HIPAA, but they will become education records protected by the Family Education Rights and Privacy Act (FERPA). I allow the persons or agencies listed above to share specific information as noted above. I understand that this is a cooperative effort by agencies involved to share information that will lead to the cooperative effort in ensuring the optimal academic performance and/or level of wellness for this student.

\_\_\_\_\_  
(Parent/Guardian Signature)                      Date                      (Witness Signature & Title)                      Date

\_\_\_\_\_  
(Student Signature if of legal age)                      Date                      (Witness Signature & Title)                      Date

**Original copy of this release should be filed in the above named student's health folder in the health services office.**

