AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO LEXINGTON SCHOOL DISTRICT ONE

I authorize _____

_____

_____

_____

(Name and Address of Healthcare Provider)

to disclose any/all medical records, including personally identifiable health information, of _____ (*student's name*) DOB: _____ to the Compliance Officer of **Lexington School District One** and his/her designee indicated below, for purposes of their involvement in the child's education, healthcare, and/or payment related to healthcare.

By initialing the spaces below, I authorize the use and/or disclosure of any such personally identifiable health information and/or medical records to the following person(s) or categories of persons:

___ School Administrators
___ School Nurse
___ Special Education Personnel
___ Individual(s) named here: _____

_____

This information is being disclosed or used for the following purposes: _____

_____

By signing this authorization, I acknowledge that:

1. The person(s) and categories of persons identified above may not be covered by federal privacy regulations, and thus, the health information might be re-disclosed and not protected by 42 C.F.R. § 164.508. However, those parties may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
2. I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits;
3. I may submit to the healthcare provider a written request for an accounting of disclosures made pursuant to this authorization;
4. I may revoke this authorization, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization;
5. Unless revoked earlier, this authorization will expire 6 (six) months after the last date of the child's enrollment with the School District; and
6. I have received a copy of this Authorization form.

_____ _____

Student's (if 18) or Personal Representative's Signature Date

Basis of Personal Representative's Authority:

☐Parent ☐Guardian ☐Foster Parent ☐Surrogate Parent

Authorization Expires on the following Date or Event: _____

To the healthcare provider:

Please send the above-named student's healthcare records to my attention at the following address:

Dr. Wendy Balough
Lexington School District One
100 Tarrar Springs Road
Lexington, SC 29072 Phone # 803-821-1101
Fax # 803-821-1281

_____

Signature of Person Requesting Information

_____

Title

_____

Print Name

10-08

School Initials _____