Campbell County School District #1 Nursing Services

Authorization for Exchange of Confidential Information

Name of Student: _____ Date of Birth: _____

As parent/guardian/adult student, I hereby request release of confidential medical information on the above student between the parties below:

School District or Public Agency:	
Address:	
Phone Number:	
Agency Contact Person:	

Agency:	
Address:	
Phone Number:	
Agency Contact Person:	

Information Requested:
☐ **Immunization records**
☐ **School health records**
☐ **All medical and/or health related records**
☐ **Other (specify):**

*** This permission is valid for one year from the date signed. A copy of this form is effective as the original.**

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district or public agency, may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Signature	Relationship	Date