Authorization to Disclose Health Information

Student Name:_____

Date of Birth: _____

I,_____, as the parent/guardian of the above-named child, hereby authorize *(Name of Physician/Practice & Address)*

_____

_____

to disclose the specific and individually identifiable health information of the above-named child to authorized person(s) in the Mariemont City School District.

Information to be disclosed: (Describe the personal health information you are authorizing to be provided or received)_____

I have read and understand the following statements about my rights:
• I may revoke this authorization, in writing, at any time.
• If not revoked, this authorization will expire one (1) year after the date on which it was signed.
• Please note: medical records provided to schools that receive federal funding are protected by the Family Educational Rights and Privacy Act (FERPA).
• I may request a copy of this signed authorization for my own records.

Signature of Parent/Guardian: _____ Date: _____

Revocation Section

I do hereby request that this authorization to disclose the health records of my child,

_____ (*Student's Name*), be revoked, effective (*Date Revoked*)_____.

Signature of Parent/Guardian: _____Date:_____