AUTHORIZATION TO RELEASE MEDICAL RECORDS

Student's Name: _____	Date of Birth: _____
Home Address: _____	
Phone Number:	

I, _____,
The parent/legal guardian of: _____
hereby authorize the release of my student's medical records to the Blue Springs R-IV School District from:

Hospital/Doctor/Clinic:			
Address:	Street:	City:	State:
		Zip Code:	
Office Number:			

This information is required for the following reason(s) (specify purpose):

- ☐ To obtain health information and treatment plans to aid and guide management and treatment of student's health condition including development and implementation of emergency action plans (EAPs), individual health plans (IHPs), and/or medical management plans.
- ☐ Immunization compliance.
- ☐ Other: _____

This authorization for disclosure is valid for one year from the date signed and I understand that I may withdraw this authorization at any time. This authorization will allow the school nurse or school administrator to share medical information with other school employees as necessary and complies with the Health Insurance Portability and Accountability Act ("HIPAA") privacy provisions.

I understand that I have the right to inspect the information disclosed.

_____

Signature of Parent/Legal Guardian Date