Skokie School District 68

Our mission is to develop children who are confident and creative learners. We provide a rigorous curriculum and a supportive school environment that promotes high achievement, encourages personal growth, and meets the unique needs of each child.

STUDENT SERVICES DEPARTMENT

9310 North Kenton Avenue
Skokie, Illinois 60076-1338
Telephone: 847/568-7504
Fax: 847/568-7599
internet: www.skokie68.org
Email - esahyouni@skokie68.org

Eva Sahyouni, School Nurse
Sharon Jacobellis, Director of Student Services

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)*

Student Name: _____ Grade: _____ Date of Birth _____

I hereby authorize:

Name:_____ Phone: _____

Address: _____ Email: _____

to exchange and disclose protected health information and/or educational records to:

Name: _____ Phone: _____

Address: _____ Email: _____

The medical information to be disclosed consists of (check all that apply):

□ medical history and/or physical □ immunization record □ vision/hearing/lead screening
□ treatment plans □ interscholastic physical □ medication records
□ nursing assessment □ Lab results □ communicable disease records
□ mental health information □ records covering the period of time from _____ to _____
□ information related to the following injury or condition _____

This authorization is valid for one calendar year starting on _____
I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their contents.

_____ _____
Parent signature Date

_____ _____
Student signature (if student is over 12 years of age and the authorization is for The release/exchange of mental health records Date