

HIPAA Authorization to Use/Disclose PHI
School/Educational Programs and Services

Patient (Student) Name _____	Date of Birth _____	Medical Record # _____
Section 1: I hereby authorize Children's Hospital Colorado to release information, as described below, to:		
Name of School or District to receive information: _____		
Address: _____		
Phone number: _____ Fax number: _____		
Purpose: For the use by the school for educational purposes, including IEP and 504 evaluations and reviews.		
Section 2: Type of records and dates to be released for educational purposes** (please select all that apply)		
<input type="checkbox"/> Provider Notes & Reports <input type="checkbox"/> Immunization Record <input type="checkbox"/> Eye Exams <input type="checkbox"/> Audiology Tests <input type="checkbox"/> Discharge Summaries		
<input type="checkbox"/> Care Plans (specify departments): _____ <input type="checkbox"/> Other: _____		
Dates of Services (between): _____ and _____		
**Please Note: The information to be released may include a <i>diagnosis or reference</i> to the following condition(s): behavioral health services/psychiatric care, sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); drug and/or alcohol abuse, or sexually transmitted diseases. Children's Colorado will not release these department specific records: Reproductive health, including pregnancy and sexually transmitted disease, HIV/AIDS, drug/alcohol treatment information, or behavioral health or psychiatric care information.		
Section 3: Method of release (please select all that apply). Fax for School Nurse/Children's Colorado Connect:720-777-7965		
<input type="checkbox"/> Verbal disclosure between provider and school <input type="checkbox"/> School Nurse access/release through Children's Colorado Connect		
<input type="checkbox"/> Children's Hospital Colorado Health Information Management/Medical Records needs to process records to send to school:		
<input type="checkbox"/> Paper <input type="checkbox"/> CD (<i>only available for records stored electronically</i>)		
<input type="checkbox"/> Mail to: _____		<input type="checkbox"/> Fax to: _____
_____		Attn: _____

I understand the following: This authorization will instantly **run out** on September 30th of each year **or** the date the patient/student becomes an adult under state law. I can ask for an expiration date sooner in writing. I may take back this authorization at any time by telling Children's Hospital Colorado in writing. I understand this would only apply to future releases of information and not information that has been already released. Information that has been released may no longer be protected by HIPAA and may be **re-disclosed**. Once the school gets this information, it may be protected by other law, such as FERPA. Children's Hospital Colorado will still give care and seek payment for care given to my child even if I do not sign this authorization. There will be no charge for copies of medical records provided directly to the school.

This authorization does not apply to information about the treatment relationship between Children's Hospital Colorado and the school nurse. I understand that information will still be shared with the school nurse for care purposes even if I don't sign this authorization.

Signature of Parent/Legally Authorized Representative _____
Date

Children's Colorado HIM • 13123 E. 16th Ave, Box 150, Aurora, CO 80045 • Ph: 720-777-4259 • Fax: 720-777-7251



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Place Patient Identification Label Here