

**HIPAA-Compliant Authorization for Release of Health Information**

**Student Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

I hereby authorize \_\_\_\_\_  
**Primary Care Provider, Address, and Phone**

to release my or my child's health information/records for the purpose listed below to:

HSSU Student Health Services  
3025 Laclede Ave  
St. Louis, MO 63103  
314-340-5052 office 314-340-5181 fax

**Description:**  
**The information to be disclosed consists of:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Purpose:**  
**This information will be used for the following purpose(s):**

- Educational evaluation and program planning.
- Health assessment and planning for health care services and treatment in school.
- Medical evaluation and treatment.
- Other \_\_\_\_\_

**Authorization**

This authorization is valid for one calendar year. It will expire on \_\_\_\_\_. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these 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.

\_\_\_\_\_

Student Signature Date

\_\_\_\_\_

Parent Signature\* Date

\*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Missouri, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for STD-HIV/AIDS, reproductive health care services, and general medical care.