HIPPA Authorization

Student Name: _____

Date of Birth: _____

In accordance with government HIPPA regulations, I hereby authorize Peninsula Adventist School's health officials to share health information and health history with the other staff members on a need to know basis. This includes the Homeroom and Special teachers that have the student in their class. The purpose of this disclosure is for the teachers to be prepared in advance for any medical emergencies.

The health information to be disclosed will be from the Health Inventory, Emergency Card, Medical Protocols, Medical Order form, and Immunizations records.

I also authorize release of medical information to _____ (name of doctor) for the treatment of my student while attending Peninsula Adventist School.

This medical information will be from the health record that is maintained in the health room by the medical staff.

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Authorization

This authorization is valid for one school year. It is valid for the duration of your child's stay at PAS. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that this information is released to help with the treatment of my student while attending Peninsula Adventist School.

_____ _____

Parent or Guardian Signature Date

_____ _____

Student Name Teacher / Grade