GENOA-KINGSTON
COMMUNITY UNIT SCHOOL DISTRICT #424

AUTHORIZATION

TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Student's Name: ________________________________ a/k/a:______________________________________

Date of Birth: _________________________________ SSN#: ____________________________________

Medical Provider: ____

Make Disclosure to: **Genoa-Kingston Community Unit School District #424**
980 Park Avenue
Genoa, IL 60135- 1098

Information to be Used and Disclosed: **Immunization and/or school physical records of student designated above**

Purpose of the Disclosure: At the request of the parental or other legal guardian for the use by Genoa-Kingston Community Unit School District #424.

Right to Revoke: This authorization may be revoked at any time by giving the provider written notice of revocation of this authorization. Revocation will not apply to information already released in response to this authorization.

Redisclosure: Once the above information is disclosed pursuant to this authorization, there is potential for redisclosure by recipient and such information may no longer be protected by federal privacy laws or regulations.

Expiration Date: This authorization shall expire one (1) year from the date of execution below.

Student's parent or legal guardian has the right to refuse to sign this authorization. The provider designated above may not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed.

Signature of parent or legal guardian ____ Date ___________

Relationship to student (authority to act): ____

Compliant with the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act (HIPAA) as amended 05/05/03
(45 C.F.R. Parts 160 and 164; 65 Fed. Reg. 82,462)

2009 - 2010