



North Yarmouth Academy
HIPAA-Compliant Authorization for Release of Health Information

Patient/Student Name: _____ **Date of Birth:** _____

I hereby authorize _____
 [insert health care provider name, address and telephone]
 to release my/my child's health information/records for the purpose listed below to:

North Yarmouth Academy & Selected Host Family
148 Main Street Yarmouth, Maine 04096 (207) 846-9051

Description:
The information to be disclosed consists of:
 All pertinent health and medical information

Purpose:
This information will be used for the following purpose(s):
 Informative knowledge and maintenance of student's medical record and medical conditions for school and selected host family. Selective information may be relayed as needed to active medical personal if student needs medical treatment.

Authorization

This authorization is valid for one calendar year. It will expire on _____ [insert date]. 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.

 Parent Signature Date

 Student 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 Maine, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, sexual assault evaluation and reproductive health care services.

Copies: Parent or student*
 Physician or other health care provider releasing the protected health information
 School official requesting/receiving the protected health information

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