North Palos
School District 117

FERPA/HIPAA CONSENT FOR RELEASE OF INFORMATION

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICAL PROVIDERS and NPD 117

Student Name: ____DOB: ____________________
I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) ____

(2)____

to provide protected health information from the above-named child's medical record to and from:

North Palos School District 117 7825 W. 103rd St., Palos Hills, IL 60465

Contact Person at School District: ____

Telephone Number: ___________________________Fax Number:______________________________

The disclosure of health information is required for the following purpose: ____

____

Requested information shall be limited to the following dates of service: From:______To: ______:

- ❏ Medical Records (Immunizations___ Physician notes___ Imaging reports___ Other_____)
- ❏ Psychological / Social Worker Reports
- ❏ Therapy Reports (Speech___ Occupational___ Physical___ Developmental___
- ❏ Other: ____

DURATION:

Unless revoked, this authorization will expire 30 days from the date of the signature on the authorization. *For mental health purposes, this authorization will expire one year from the date of signature.*

RESTRICTIONS:

Law prohibits NPD 117 from making further disclosure of my health information unless NPD 117 obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

North Palos
School District 117

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me, and delivered to the NPD 117 school district. My revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.*

RE-DISCLOSURE:

I understand that the Requestor (NPD 117) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information may be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure. I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this Authorization.

I have a right to receive a copy of this Authorization. I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information.

APPROVAL:

Printed Parent/Guardian Name ____

Signature ____

Relationship to Student ______________________ Date ______________________

Signature of Patient age 12 or over ______________________ Date ____________

Witness ____________________________________ Date ______________

Witness is required for mental health releases.

7825 W. 103rd Street – Palos Hills, IL 60465 | P (708) 598-5500 F (708) 599-3138 www.npd117.net