**Anchorage School Based Health Centers**
**c/o Christian Health Associates, 1825 Academy Dr., Anchorage AK 99507**
**Clark Clinic: 907-742-7782 Begich Healthy Spot Clinic: 907-742-0535**

## AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

| Patient/Student Name: | Date of Birth: |
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You have consented to your child receiving healthcare services from Anchorage School Based Health Centers. ASBHC will create a medical record for your child. This information is separate from health information about your child in records maintained by the school nurse. Both types of records are confidential and are protected by two important laws. First, the Health Insurance Portability and Accountability Act (HIPAA) protects personal health information in medical records kept by ASBHC. Second, the Family Educational Rights and Privacy Act (FERPA) protects personal information in education records maintained by ASD and school nurses.

**SERVICES AT ANCHORAGE SBHCs ARE DESIGNED TO IMPROVE YOUR CHILD'S HEALTH AND WELL-BEING THROUGH A COORDINATED EFFORT WITH YOU, YOUR CHILD, THE SCHOOL NURSE, SCHOOL COUNSELOR, AND YOUR CHILD'S PRIMARY CARE PHYSICIAN.** To accomplish this, it is important that information be shared between these providers regarding your student's current health and health history.

The laws discussed above provide that your child's health information is confidential and, in most instances, cannot be released to any person or agency without your written consent. However, the laws do permit healthcare providers to share information, without consent, if necessary to meet your child's treatment needs. Personal health information may be provided to the school nurse for the express purpose of the school nurse's assessment and medical treatment of a student. Personal information may also be shared with school counselors related to the academic and social-emotional well being of your student. Personal health information may also be shared between the SBHC and your primary physician in order to facilitate the care and treatment to your child when the information is used only to treat your child and is otherwise maintained as confidential. A school nurse can release personal health information in an emergency when the information may be necessary to protect the health or safety of your child or other persons. Finally, information related to your child's immunization status may be shared among the school nurse, Anchorage SBHCs, and your child's primary provider.

There may be additional information regarding your child's health that should be shared in order to have a complete medical history for your child. We ask that you provide consent for this information to be shared. This consent does not mean that your child's complete medical file will be copied and disseminated. However, it will permit the school nurse, Anchorage SBHCs, and your child's primary provider to share information that the individual or entity believes necessary or helpful to improve your child's health and well-being. This will permit your child to fully benefit from Anchorage SBHC services.

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| Initial Here | I authorize my child's entire record to be released to the School Nurse and/or School Counselor, as needed (required for ASBHC services). |
| Initial Here | I authorize my child's entire record to be released to my child's primary care provider (regular doctor): |

*Signature Required on Page 2*

| Patient/Student Name: | Date of Birth: |
|---|---|

**ASBHC is authorized to release patient health information as follows:**

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| **Information to be used or disclosed:** | ☐ Entire record including, without limitation, personal health information and other records pertaining to treatment, payment or services sought or received, including non-medical services and the records listed below (if this box is checked, all boxes below are presumed to be checked)<br>☐ Health History ☐ Health Screening<br>☐ Physical Exam Records ☐ Medication Records<br>☐ Progress Notes ☐ Other (specify)_____ |
| **Name of Organization(s), person(s), or class of persons authorized to receive health information:** | ☐ Other (specify)_____<br>☐ Other (specify)_____<br>☐ Other (specify)_____<br>☐ Other (specify)_____ |
| **Purpose(s) for which health information may be used/disclosed** | ☐ At the request of the individual's personal representative<br>☐ Other (specify)_____ |
| **Authorization Expires On:** | ***If this is not completed, authorization will expire six months after the student completes 8th grade or six months after the student is no longer enrolled at Begich or Clark Middle School.*** |

1. I understand that I have the right to revoke this authorization, except to the extent that it has already been relied upon or records have already been released. I may revoke this authorization by writing to ASBHC.
2. I understand that information disclosed under this Authorization may be redisclosed by the recipient. The federal privacy rules may not protect my health information once the recipient rediscloses my health information.
3. I understand that I may decline to sign this authorization. I understand that covered entities may not refuse to treat me or otherwise condition benefits on signing this authorization, except that a provider may refuse to provide me with research-related treatment if I do not authorize use or disclosure of my health information for research purposes. Also, if the purpose of my treatment is solely to disclose health information to a third party, the provider may refuse my treatment if I do not agree to authorize disclosure of my health information to that third party.

**My signature below acknowledges that I understand that certain personal health information from the records of my child may lawfully be shared in order to meet my child's emergency or treatment needs. Additionally, to the extent my consent is legally required to permit sharing of information from my child's medical or education records, I consent to the sharing and release of information. This consent is limited to the sharing of information as may be deemed medically relevant and necessary for the physical health and well-being of my child.**
**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM**

| Authorized Representative (Parent/Guardian) Name: | |
|---|---|
| Authorized Representative Relationship to Patient: | |
| Authorized Representative (Parent/Guardian) Signature: | Date: |

**A COPY OF THIS SIGNED AUTHORIZATION**
**MUST BE PROVIDED TO THE PATIENT OR PATIENT REPRESENTATIVE**