

**SANBORN REGIONAL SCHOOL DISTRICT**

SRSD File: JLCCA-R1

**HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH FORMATION  
BLOOD/BODY FLUID EXPOSURE INCIDENT (STUDENT)**

Patient/Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

\_\_\_\_\_ [insert name of school official]

\_\_\_\_\_ [insert name of school/school district]

\_\_\_\_\_ [insert school address and telephone/fax]

**Description:**

The information to be disclosed consists of:

Results of blood tests on the SOURCE person for the presence of HIV and HBV and HVC antibodies, performed after a blood/body fluid exposure incident on \_\_\_\_\_ (date)

**Purpose:**

This information will be used for the following purpose(s):

This information will be shared only between the PHYSICIAN OF RECORD of the EXPOSED person involved in the blood/body fluid exposure incident listed above, and the PHYSICIAN OF RECORD listed in section one of this form. This information is required to facilitate treatment of the EXPOSED person.

School official will only facilitate contact between physicians.

**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 New Hampshire, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, care and testing for HIV/AIDS/STDs, 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

**History:**

Original: March 5, 2008

Renewed: January, 23, 2019

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