Covington ISD
Authorization for Release of Protected Health Information

This authorization is provided in accordance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPPA"), that went into effect on April, 2003.

I, ______________________________, am the parent/ guardian of______________________________ the
Name of Parent/ Guardian Name of Student
individual receiving treatment and hereby authorize the use or disclosure of his or her protected health information as described in this Authorization.

This document authorizes the staff of Covington ISD to receive health information, on a "need to know" basis, with the intent of providing consistent and quality health care assistance, while in attendance at this specified campus and field trips which have been parent authorized.

The campus nurse can receive and send communication regarding any medical examination reports and conclusions, to and/or form the student's health care provider, when such knowledge would impact the health care of this student while attending school.

This specified information will be used for the purpose of providing appropriate health care for this student, classroom modifications, other campus activities and emergency response.

RIGHT TO REVOKE: I understand that I have the right to revoke this Authorization at any time by notifying the school, in writing.

I understand that the revocation is only effective after it is received and logged by campus nurse or authorized designee. I understand that I cannot revoke this Authorization to the extent that the school has taken action in reliance of this Authorization.

I understand that this Authorization is not required for Covington ISD to use or disclose this information for the purpose of treatment, or if the use or disclosure is otherwise permitted by the Privacy Standards, and that any revocation of this Authorization will have no effect on such uses or disclosures.

I understand that I am entitled to receive a copy of this Authorization.

I understand that this Release of Information Form can be reviewed in 6 months.

____________________ ______________________________

Date Parent/ Guardian Signature