HIPAA Authorization

Cedar Falls Community School District

STUDENT NAME:_____ **DATE OF BIRTH:**____/____/_____

NAME OF PARENT OR GUARDIAN:_____

ADDRESS: _____

I, the parent or guardian of the above named student (the "Student,") understand that a federal law known as the Health Insurance Portability and Accountability Act ("HIPAA") limits the disclosure of the Student's protected medical information. The Student has been diagnosed with a life threatening allergic condition. I am signing this Authorization because it is crucial that the Student's medical providers readily communicate with Cedar Falls Community School District (the "District") in order to allow the District to appropriately accommodate the Student's allergic condition and develop a plan to properly address any situation in which the Student is exposed to an allergy.

Therefore, pursuant to 45 CFR 164.508(a)(1), any covered entity (a health care provider, as defined by HIPAA) is permitted to disclose the protected health information discussed in this Authorization in compliance with federal law.

AUTHORIZATION

I hereby authorize all covered entities, as defined by HIPAA, to disclose the following information:

> All health care information, reports and/or records in any way related to the Student's allergic condition or any other condition that causes, or may cause, the Student to experience an allergic reaction due to exposure to an allergen, including information concerning said medical condition, history, diagnosis, testing, prognosis, treatment, and identity of health care providers, whether past, present or future, and any other information related to said condition. Additionally, this disclosure shall authorize the District, or its representatives, to ask questions and discuss the protected health information with any medical provider, even if I am fully competent to ask the same questions and discuss this matter at any time. It is my intention that this Authorization be interpreted broadly to allow the District to learn as much information as it may consider appropriate to properly address the Student's allergic condition.

to the following authorized persons:

> The Cedar Falls Community School District, and all of its employees, agents, and representatives.

TERMINATION

This authorization shall terminate on the first to occur of: (1) the Student, for any reason, is no longer enrolled at the District or (2) the actual receipt of a written revocation of this Authorization, signed by the Student, or the Student's parent, guardian or representative. Proof of receipt of written revocation may be by certified or registered mail, facsimile, or any other method demonstrating actual receipt by the covered entity, and shall be effective upon its actual receipt by the covered entity. This authorization is not affected by the Student's subsequent disability or incapacity.

RE-DISCLOSURE

I understand that the District is not a covered entity under HIPAA, and the use or disclosure by the District of the information provided pursuant to this Authorization is no lot subject to HIPAA. However, I understand that the District's use or disclosure of this information is governed by laws related to student privacy, including the federal Family Educational Rights and Privacy Act ("FERPA") and Iowa public records confidentiality law (Iowa Code § 22.7(1)). No covered entity shall require the District to indemnify the covered entity or agree to perform any prerequisite act for the covered entity to comply with this Authorization.

USE OF PHOTOCOPY OR FACSIMILE

A copy or facsimile or this original Authorization shall be accepted as though it were the original.

CURRENT TREATING PHYSICIAN

Please list below the physician or other health care providers, who is currently treating the Student for any allergic condition. Please attach an additional page if the Student is being treated by more than one physician or health care provider. Note that this Authorization applies to all health care providers, regardless of whether said provider is named below.

NAME OF PHYSICIAN:_____ **CLINIC:**_____

TREATED ALLERGY:_____

ADDRESS:_____ **CITY, STATE:**_____

PHONE NUMBER:_____ **ZIP:**_____

Signed on this ____ day of _____, 20___.

Signature:_____

Printed Name:_____

Relation to Student:_____