Northern Bedford County School District

Office of the School Nurse
Starla J. Snyder, MSN, RN, NCSN

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, parent/guardian of ____
Student Name/DOB

of ____
Address

authorize ____
Name of Physician/Practice/Facility

to provide health information to Northern Bedford County School District, 152 NBC Drive, Loysburg, PA 16659.

The information to be released is (state specific documents, time period, etc.): Physical examinations, immunization records, dental examinations, and any other pertinent information needed to meet mandated services.

Purpose or need for the information requested:

√ Compliance with Article XIV of the Pennsylvania Public School Code

I understand that this consent is voluntary and that I may revoke this authorization at any time, except to the extent that action based on this consent has already been taken, by written, dated, and signed communication. This consent will remain in effect until the above named graduates from high school. I also understand that health records may include physical examinations, immunization records, dental examinations, and any other pertinent information needed by the school nurse to meet mandated services required by the state according to Article XIV of the Pennsylvania Public School Code.

I understand that with disclosure of this information, I have waived any confidentiality rights protected under the federal HIPPA privacy rule for the purpose noted above.

I understand that I may refuse to sign this authorization. However, in refusing, I take full responsibility in obtaining the required documentation as outlined in Article XIV of the Pennsylvania Public School Code.

____
Signature of Parent/Guardian (Relationship) Date

____
Witness Date

A copy of this authorization has been ______accepted _______ rejected by the parent/guardian.

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

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