



FURTHER CONSENT AND AUTHORIZATION FOR USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION AND EDUCATION RECORD

The aforementioned child has my consent to receive services offered by the School Health Center located in Urbana High School. I have been informed of and understand the scope of services which may be provided. I also understand that although I am encouraged to be present for appointments, it is not required and that by signing below I am authorizing the Health Center to provide services to my child in his/her best interest. In the event that during the school day I am not available to transport my child (if applicable) to the Urbana School Health Center, I authorize the Urbana School District to arrange transportation to access Health Center services.

I FURTHER UNDERSTAND THAT CONFIDENTIALITY BETWEEN MY CHILD AND SCHOOL HEALTH CENTER PROFESSIONALS WILL BE ENSURED AS DESIGNATED BY LAW AND PROVIDED SERVICES WILL NOT BE DISCUSSED WITH THE PARENT/GUARDIAN UNLESS THE CHILD AGREES. UNDER ILLINOIS LAW, A MINOR OVER AGE 12 HAS THE SAME CAPACITY AS AN ADULT TO CONSENT TO CERTAIN HEALTH SERVICES AND NO PARENTAL PERMISSION IS REQUIRED FOR SUCH SERVICES.

UNDERSTAND that if a referral is made for your child to receive health care services at the STUDENT HEALTH CENTER, the SCHOOL DISTRICT will make available to the CENTER as they may be requested by the CENTER, or are necessary as part of the referral or services to be provided your child, your child's education records, including special education records, if any; and mental health, HIV, and/or substance abuse records. These records may also be used at the CENTER for your child's education evaluation and program planning, medical evaluation and treatment, health assessment and planning for health care services and medical treatment. IF THERE ARE ANY EDUCATION RECORDS OR HEALTH CARE INFORMATION IN POSSESSION OF THE SCHOOL DISTRICT THAT YOU DO NOT WANT GIVEN TO THE HEALTH CARE CENTER AS PART OF THE REFERRAL PLEASE DESCRIBE WHAT RECORD OR INFORMATION YOU DO NOT WANT THE SCHOOL DISTRICT TO RELEASE IN THE SPACE BELOW:

\_\_\_\_\_

\_\_\_\_\_

I (WE) UNDERSTAND THAT I AM CONSENTING TO, AND AUTHORIZING THE USE OF, ALL RECORDS OF MY CHILD DESCRIBED ABOVE UNLESS I HAVE SPECIFICALLY DESIGNATED IN THE SPACE ABOVE THOSE RECORDS NOT TO BE RELEASED.

This authorization is valid for one calendar year and will expire on \_\_\_\_\_. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health 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 understand that I have the right to inspect and copy any records to be released pursuant to this authorization, to challenge the contents, and to limit any such consent to designated records or designated portions of the information contained therein.

_____	_____
Parent/Guardian Signature	Date
_____	_____
Student Signature	Date
_____	_____
Witness signature	Date

Student signature required if the minor student is over age 12 and if this authorization is for the release of mental health records.

I acknowledge that Urbana School District No. 116 is not involved in the operation or control of the Health Center and that the Health Center operates independently from the School District. I understand that because the School District is not involved in the medical care and treatment, the School District is not required to provide me notification, pursuant to the Protection of Pupil Rights Act, 20 U.S.C. §1232h, of any non-emergency, invasive physical examinations conducted at the Health Center. I understand that school officials may have the occasion to refer my child to receive services at the Health Center. I hereby give the School District consent to make such referrals when it is School District personnel's opinion that a referral would benefit my child. I further understand that any issues or questions with regard to the nature and extent of health care services provided my student, or the performance of the health care services, are to be addressed with the representatives of the health service providers and not the School District.

_____	_____
Parent/Guardian Signature	Date
_____	_____
Parent/Guardian Signature	Date

**Eligibility:**

**Child's School** \_\_\_\_\_ **Child's Homebase Teacher** \_\_\_\_\_ **Grade**  
\_\_\_\_\_

**IF YOU HAVE MEDICAL COVERAGE, PLEASE COMPLETE THE FOLLOWING INFORMATION**

**Insurance Type:**     **KIDCARE**                     **Medicaid**                     **HMO**                     **PPO/POS**                     **Indemnity**

**Recipient ID#** \_\_\_\_\_

**If yes: Name of insured, i.e., parent/guardian** \_\_\_\_\_

**Social Security Number / ID of Insured** \_\_\_\_\_

**Name of Employer** \_\_\_\_\_

**Policy Number** \_\_\_\_\_ **Group Number** \_\_\_\_\_

**Address of Insurance Company or HMO** \_\_\_\_\_

**Phone Number of Insurance Company or HMO** \_\_\_\_\_

**NO INSURANCE** Do you qualify for the Free and Reduced Rate School Lunch Program? Yes \_\_\_ No \_\_\_ Don't Know \_\_\_