HIPAA Compliant Authorization for Exchange of Health and Education Information

I hereby authorize Southampton Academy to exchange health and education information/records for the purposes listed below:

- Health assessment and planning for healthcare services and treatment in school
- Educational evaluation and program planning
- Medical evaluation and treatment
- Other:
  _____

Student Name:_____Grade:_____

I agree that a photocopy of this authorization is as valid as the original. This authorization granting permission to exchange education and health information remains in effect until revoked by parent(s) or guardians on file with Southampton Academy and will begin upon enrollment each school year and expire on June 30th of the current year. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____
Signature of Parent(s) or Guardian in contract agreement with Southampton Academy

_____
Date

_____
Signature of School Nurse or Authorized School Official

_____
Date