KCS
KNOX COUNTY SCHOOLS

STUDENT SUPPORT SERVICES
Authorization and Request of Protected Health Information (PHI) Medical/Mental Health

Student/Patient Name:	Date of Birth:	Social Security No.

School:	School Specialist:

Health Care Provider Name:	Requester's Name/Address:
Health Care Provider Address:	KNOX COUNTY SCHOOLS P.O. Box 2188 400 W. Summit Hill Drive Knoxville, TN 37901-2188 attn: ☐ **Special Education** ☐ **Health Services** ☐ **Homebound** ☐ **School File**

This authorization will expire on the following: *(Fill in a date or event, but not both.)*

Date: Event:

Purpose of Disclosure: ___ Educational Programming
___ Other:

Description of Information to be Disclosed

Please describe the information to be disclosed. Then please check the items listed below which fit your request. Please note that some of these records include mental health records.

Description:	Date(s):
___ Suspension information ___ Attendance ___ Grades ___ All information impacting the student's education. ___ Other:	

___ All PHI in medical record	___ Vision report	___ IEP/M team note/plan
___ Psychological report	___ Diagnostic reports	___ IEP/Service Plan
___ Psychiatric report	___ Speech Language report	___ Oral exchange of information
___ Physician orders	___ OT report	___ Written exchange of information
___ Hearing report	___ PT report	___ Meet with student while at school
___ Clinical test reports	___ Discharge summary	___ Other: _____
___ Medication sheets	___ Admission notes	___ Other: _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (initial)

I understand that:
1. I may refuse to sign this authorization and doing so is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will be not affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Student (if 16 or older)/Patient or Guardian/Parent of Student	**Date:**
Print Name of Student/Patient's Representative:	**Relationship to Student/Patient:**
Witness:	**Date:**