Tuscaloosa County School System
Health Services
P.O. Box 2568
Tuscaloosa, AL 35403-2568

REQUEST FOR CONFIDENTIAL HEALTH/MEDICAL RECORDS

Please send health/ medical records and information regarding:

Student: _____ DOB: _____

Address: _____

Phone: _____

Please send:

_____ Health Information and Medical Records only

_____ Other: _____

by secure fax/mail to the attention of: _____.

In signing this request, I certify that the fax number (205) 247-4166 is located in a secure and confidential location unable to be accessed by anyone other than TCSS Health Services nursing staff.

_____	_____	_____	_____
Tuscaloosa County School System Health Services School Nurse	School's Name	Office Phone	Date

NOTE: HIPPA – compliant authorization/release signed by the above named student's parent/guardian/ legal representative should accompany this request

Total Pages Sent: _____

Other Comments:

_____

_____

Tuscaloosa County School System
Health Services
P.O. Box 2568
Tuscaloosa, AL 35403-2568
Head Nurse: (205)342-2798 Fax: (205)247-4166

AUTHORIZATION TO OBTAIN AND EXCHANGE CONFIDENTIAL HEALTH/MEDICAL RECORDS AND INFORMATION

The undersigned parent/guardian/legal representative of: _____, (DOB: _____) a student in the Tuscaloosa County School System (TCSS), hereby authorize the exchange of health/medical records and information to occur between TCSS Health Services nursing staff and: _____

Address: _____ Phone: _____.

USE AND DISCLOSURE shall be for the planning and implementation of any health related care to be provided during school hours and school-related activities.

I specifically authorize the release/exchange of the following records pertaining to my child, if such information/records exist:

_____ Health information and medical records only

_____ Other: _____

I further authorize the TCSS Health Services nursing staff to share such records and/or information pertinent to my child's school progress with school personnel and/or other health care providers to which my child may be referred. In signing this authorization, I am certifying to the TCSS Health Services nursing staff and the above named provider that I have the lawful right to make this request and that I consent to the release of the above information. I understand and agree that unless earlier revoked, this authorization will expire in 180 days from the date shown below.

_____ _____

Date Signature of Parent, Guardian, or Legal Representative