Windsor CHARTER ACADEMY
GROWING LIFE-LONG LEARNERS

HIPPA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and accountability Act, 45 C.F.R Parts 160 and 164)

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to Windsor Charter Academy.

2. Extent of Authorization

I authorize the release of my complete health record, including the following:

Physical health records
Mental health records
Other (please specify): _____

3. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law

_____ _____
Printed name of student Date

_____
Signature parent/guardian

_____
Printed name of parent/guardian and relationship to student