6058 W. 900 North, McCordsville, IN 46055
Phone: (317) 813-4626 Fax: (317)-813-4665

# FERPA/HIPAA CONSENT

## AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTH CARE PROVIDERS AND GEIST MONTESSORI ACADEMY

Completion of this document allows the disclosure and/or use of individual identified education records and health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

**USE AND DISCLOSURE INFORMATION**:

Patient/Student Name: ___________________________________________________________________________

Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) ___________________________________

(2) ___________________________________

to provide health information from the above-named child's medical record to and from:

Geist Montessori Academy, 6058 W 900 N, McCordsville, IN 46055

Contact Person at the School: _____________________________________

Telephone: 317-813-4626 Fax: 317-813-4665

The disclosure of health information is required for the following purpose:

______________________________________________________________________________________________

**Description of Information to be Disclosed: I authorize the release and disclosure of any and all medical records, histories, reports, notes, diagnostic films or imaging, and all such other health information pertaining to the above named child , a minor, of whatever kind and character, and including but not limited to any psychiatric, psychological or mental health records, from [Date] to the date this release is presented for such records, to the persons/entities identified herein.**

______________________________________________________________________________________________

**Signed by Parent/Guardian**

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