St. Viator Parish School
2024-2025
Authorization for Use or Disclosure of Health Information

Patient/Student Information
Name: _____
(Last) (First) (MI)
Date of Birth: _____

I hereby authorize, _____,
(Name of health care provider)
to provide health information from the above named child's medical record to and from:

St. Viator Parish School
4246 S. Eastern Ave., Las Vegas, NV 89119
Phone: (702) 732-4477
Fax: (702) 732-4418

Description
The health information to be disclosed consists of:

☐ Medical and/or related health records

☐ Psychological evaluations, behavioral assessments and/or social work reports

☐ Appropriate agency reports (if any)

The Education Information to be Disclosed of Consists of:

Purpose: This information will be used for the following purpose(s):

1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school
3. Medical evaluation and treatment
4. Other: _____

Authorization
This authorization is valid from 2024 to 2025 school year. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I understand that St. Viator Parish School will protect this information as prescribed by the Family Education Rights and Privacy Act (FERPA) and I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____ _____
Parent Signature Date

_____ _____
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form

Copies

☐ Parent or Student*

☐ Physician or Other Health Care Provider Releasing the Protected Health Information

☐ School Official Requesting/Receiving the Protected Health Information