



Tri-County Special Education Joint Agreement
Jackson, Perry & Union Counties

1725 SHOMAKER DRIVE Murphysboro, Illinois 62966

Phone: 618-684-2109 FAX: 618-687-1638 C.W. (Chuck) Hamilton, Director

Patient/Student Name: _____ Date of Birth: _____

I hereby authorize _____

(Health Care Provider Name, Address and Phone Number)

To release my/my child's health information/records for the purpose listed below to:

Tri-County Special Education
1725 Shomaker Drive
Murphysboro IL 62966
Phone: (618) 684-2109 FAX: (618) 687-1638

Description:

The information to be disclosed consists of:

Purpose:

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

Authorization

This authorization is valid for one calendar year. It will expire on _____ (insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Parent's Signature

Date

Student's 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.