Virtual Hospital/ Homebound Services

Compliant Authorization for Exchange of Health and Education Information
(The Health Insurance Portability and Accountability Act - HIPAA)

Requesting School: Georgia Connections Academy
2763 Meadow Church Rd Suite 208
Duluth, GA 30097
Fax (678) 623-5249

A. Student Information

Student Name: _____
Last First MI

Address: _____

Date of Birth: _____

Parent/Guardian: _____
Last First MI

Phone: (H) _____(W) _____ (C) _____

School Name: Georgia Connections Academy Grade: _____

Counselor/Social Worker: _____

I hereby authorize_____
(Health Care Provider's Name and Title)

at_____
(Health Care Provider's Address and Telephone Number)

and _____
(Name and Title of School Official)

at Georgia Connections Academy

To exchange health and education information/records for the purpose(s) listed below.

Virtual Hospital/ Homebound Services

Description

The health information to be disclosed consists of the following:

_____

_____

_____

_____

_____

_____

The education information to be disclosed consists of the following:

_____

_____

_____

_____

_____

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

Authorization:

This authorization is valid for one year or as specified: _____

It will expire on: _____

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by Georgia Connections Academy, may no longer be protected by HIPAA, but they will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

_____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature Date

_____

Student Printed Name Date

_____

Student Signature Date