Health/Medical Records

When applicable, District schools will comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of protected health information that it receives, obtains, transmits or sends. The Board of Education designates the _____ as its HIPAA Privacy Officer.

Student education records, including personally identifiable health information, maintained by the District is subject to and protected by the Family Educational Rights and Privacy Act (FERPA). Both the United States Department of Health and Human Services and the United States Department of Education Family Policy Compliance Office have stated that student records under FERPA are not subject to HIPAA. Therefore, District schools will comply with FERPA's confidentiality provisions rather than HIPAA's.

The District will seek Medicaid eligibility information to determine if services to a student may be billed. Bills will be processed electronically for Medicaid reimbursement for qualified services to eligible special education students. The District will comply with HIPAA's electronic transactions requirements. Procedures and safeguards will be developed to protect the privacy of health information and prevent wrongful user and disclosure. At a minimum, the policy and procedure for student records will comply with the Family Educational Rights and Privacy Act of 1974 (FERPA) with assurances that the District has obtained authorization from the parent or adult student prior to the release of protected health information for the purpose of Medicaid billing. Individuals involved in the Medicaid billing process for the District shall be trained on the privacy procedures. Discipline shall be imposed, up to and including discharge, for staff that wrongfully uses or discloses protected health information.

Legal Reference: Connecticut General Statutes

1-19(b)(11) Access to public records. Exempt records.

10-15b Access of parent or guardians to student's records.

10-154a Professional communications between teacher or nurse & student.

10-209 Records not to be public

46b-56 (e) Access to Records of Minors.

Connecticut Public Records Administration Schedule V - Disposition of Education Records (Revised 1983).

Federal Family Educational Rights and Privacy Act of 1974 (section 438 of the General Education Provisions Act, as amended, added by section 513 of P.L. 93-568, codified at 20 U.S.C.1232g.).

Health/Medical Records, continued

Legal References: (continued)

Dept. of Educ. 34 C.F.R. Part 99 (May 9, 1980 45 FR 30802) regs. implementing FERPA enacted as part of 438 of General Educ. provisions act (20 U.S.C. 1232g)-parent and student privacy and other rights with respect to educational records, as amended 11/21/96.

USA Patriot Act of 2001, PL 107-56, 115 Stat. 272, Sec 507, 18 U.S.C. §2332b(g)(5)(B) and 2331

PL 107-110 "No Child Left Behind Act of 2001" Sections 5208 and

42 U.S.C. 1320d-1320d-8, P.L. 104-191, Health Insurance Portability and Accountability Act of 1996 (HIPAA)

65 Fed. Reg. 50312-50372

65 Fed. Reg. 92462-82829

63 Fed. Reg. 43242-43280

67 Fed. Reg. 53182-53273

5125.11
Form #1

HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient/Student Name: _____ Date of Birth: _____

I hereby authorize _____ *[insert health care provider name, address and telephone]* to release my/my child's health information/records for the purpose listed below to:

_____ *[insert name of school official]*

_____ *[insert name of school/school district]*

_____ *[insert school address and telephone]*

Description:
The information to be disclosed consists of: _____
_____
_____

Purpose:
This 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 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. In Connecticut, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

Developed collaboratively with CT State Department of Education & CT Chapter, American Academy of Pediatrics

5125.11
Form #2

HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient/Student Name: _____ Date of Birth: _____

I hereby authorize _____ *[insert health care provider name, address and telephone]* to release my/my child's health information/records for the purpose listed below to:

_____ *[insert name of school official]*

_____ *[insert name of school/school district]*

_____ *[insert school address and telephone]*

Description: *The information to be disclosed consists of:*

Sample: Physical Health Assessment and Immunization Record required by Connecticut General Statues (CGS) 10-206 (mandated health assessment for school entry, grade 6 or 7, grade 10 or 11); and CGS 10-204 (required immunizations for school attendance).

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

Sample: This information is needed to ensure school entry and continued attendance and to promote safety in the school setting for the student and the school community.

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 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. In Connecticut, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

Developed collaboratively with CT State Department of Education & CT Chapter, American Academy of Pediatrics

5125.11
Form #3

HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient/Student Name: _____ Date of Birth: _____

I hereby authorize _____ *[insert health care provider name, and title]* and _____ [insert name & title of school official] to exchange health and education information/records for the purpose listed below.

_____ *[insert address& telephone of school/school district]*

_____ *[insert address and telephone of health care provider]*

Description:

The health information to be disclosed consists of: _____
_____

The education information to disclosed 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 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 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. In Connecticut, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information