Lone ★ Star
Circle of Care

HIPAA and FERPA Consent
Authorization for LSCC and GISD to share information

Part 1: HIPAA Disclosure to GISD. Complete Part 1 of this form to allow Lone Star Circle of Care (LSCC) to share the named student's identifiable protected health information (PHI) with school officials at Georgetown Independent School District (GISD), as set forth below and in accordance with federal healthcare privacy laws (45 CFR 164.508). This authorization does not authorize the sharing of the student's full medical record.

Individual / Student: _____
First Name Last Name MI Date of Birth

Authorization. I authorize LSCC and its affiliated clinics to disclose the named student's PHI to GISD, including GISD administrative officials and licensed care professionals. I permit and request my child's information to be shared with such persons when, *in the professional judgment of an LSCC provider*, it is necessary to protect and provide for the student's best interest or to provide for appropriate care coordination between LSCC and school officials. Common examples of situations in which information might be shared include:

- Alerting school officials if emergency care for the student is needed
- Coordinating appointments with the student's classroom schedule
- Coordinating prescription drug administration or managing allergies
- Communicating appropriate information to athletic trainers and coaches
- Alerting school officials if the student poses a danger to him- or herself, or others

Duration and Revocation. I understand this authorization is effective immediately and will expire one year from the date of my signature. I may revoke this authorization at any time by giving written notice to LSCC, c/o Privacy Officer at 205 E. University Ave., Suite 200, Georgetown Texas, 78626. I understand that revocation will not affect any action that LSCC took in reliance on this authorization before receiving my written notice of revocation.

Re-disclosure and FERPA Protection. I understand that any information disclosed by LSCC will no longer be protected under HIPAA, but that GISD and school officials must protect the information as required by the Family Educational Rights and Privacy Act (FERPA) and that this information may become part of the student's educational record. The information may be shared with individuals working at or with GISD for the purposes of providing safe, appropriate, and least restrictive educational settings, school health services, or other academic or extracurricular programs. Sharing this information outside of GISD will generally require my consent.

Authorization not required to receive care or treatment. I understand that refusing to sign this form will not affect the named student's ability to receive care from LSCC. However, if I refuse, some school services may be delayed or involve additional inconvenience. Finally, I understand that even if I do not sign this authorization, LSCC may share information with a licensed health care professional employed by GISD to the extent the professional is involved in the student's health care.

Approval: _____
Printed Name Signature Date

_____ _____
Relationship to Student Area Code and Phone Number

Part 2: FERPA Disclosure to LSCC. For the student named above, complete Part 2 of this form to allow GISD to share the student's educational records with LSCC. You are not required to sign either Part 1 or Part 2 of this form to receive services at LSCC. You may sign only Part 1 *or* Part 2, or you may sign *both* Part 1 and 2.

Authorization. I authorize GISD to share the named student's FERPA-protected educational records, including, but not limited to, school health records and the student's class schedule, with LSCC personnel. I understand this authorization will help ensure care is properly coordinated between LSCC and school officials, counselors, and nurses. FERPA does not apply to information provided directly by the student or parent to LSCC in LSCC's capacity as a health care provider. Such information is considered part of the student's LSCC medical record and is protected under HIPAA. I understand refusing to sign this consent will not prevent my child from receiving care at LSCC, but it could make care coordination and scheduling appointments more difficult. I understand that my consent is voluntary and can be revoked at any time.

Approval: _____

Printed Name Signature Date

_____

Relationship to Student Area Code and Phone Number