FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
520 Fifth Ave. Fairbanks, AK 99701 (907) 452-2000

AUTHORIZATION FOR RELEASE OF IMMUNIZATION/ TUBERCULOSIS RECORDS

The purpose of releasing this information is to allow schools, childcare facilities and other centers that house school-age children to comply with Alaska's **"No-Shots No-School"** law. In many cases, the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires written authorization before personal medical information can be released by a health care provider or health care organization. This form authorizes only the release of immunization records and/prior confirmation of tuberculosis screening. **I understand that this does not authorize release of any other medical information.**

Student _____ Birthdate _____

Parent/Guardian _____ School _____

Health Care Provider _____

Information to be Released:

[ ] Immunization records
[ ] Tuberculosis screening and results

I hereby authorize the disclosure of immunization records and / or tuberculosis screening information as described above. I understand that this authorization is voluntary. I understand that a health care provider may not condition treatment on whether I sign this authorization. I understand that if the person(s) or organization(s) authorized to receive this information is not a health plan or health plan provider, the released information *may* no longer protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may revoke this authorization at any time by notifying the organization in writing. If I do revoke this authorization, I understand it won't affect actions taken before my revocation was received. I understand that I may request a copy of this authorization.

Please check ONLY one:

[ ] I additionally authorize the re-disclosure of immunization records and/or tuberculosis screening information to other school or health care authorities should my child move to another school or school district AND I understand that this authorization to re-disclose will expire when the student reaches the age of majority or when this authorization is revoked.

[ ] I DO NOT authorize further re-disclosure of this information and request that this authorization expire: When student moves or graduates from the school or organization listed above or when this authorization is revoked. ___ Other (specify date) _____

Signature of parent/guardian _____ Date _____

NUR
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