

## Physician/Medical Provider - School Information Release

This form will authorize the exchange of information between the Physician/Medical Provider and school professionals as it relates to the diagnosis/condition confining the student to the home or hospital preventing the student from participating in the day-to-day activities at home and school. Once complete, this form should be returned to the school, emailed to [hip.dcps@k12.dc.gov](mailto:hip.dcps@k12.dc.gov), or faxed to 202-654-6020.

The District of Columbia Public Schools (DCPS) adheres to the standards and obligations set forth under the Family Educational Rights and Privacy Act (FERPA) (20 USC § 1232g) and the Health Insurance Portability and Accountability Act (HIPAA) (42 USC § 1320d) protecting the privacy of student information.

<b>Release of Information</b>	Patient/Student's First & Last Name:	Parent/Guardian's Name:	Phone number:
	Patient/Student's School & District:	Principal's Name (if known):	School phone number:
	I, the undersigned, authorize the release of information regarding the above-named student between the District of Columbia Public Schools and appropriate school personnel and the authorized medical team and/or assigned office personnel.		
	Parent/Guardian's Signature:	Date:	If applicable, my consent expires:
	Not included in this release are:		

<b>Physician/Medical Provider Contact Info</b>	Physician/Medical Provider (PCP, CNMC, PIW, other) Name:	Phone Number:	Fax Number:
	Mailing Address:	E-mail address:	
	If not you, who is the best contact person:	Phone Number:	Fax Number:
	Mailing Address:	E-mail address:	
	Preferred Method and Time for Contact:		

<b>School Info</b>	District of Columbia Public Schools	School Name:	
	School Contact:	Position:	
	Phone:	Email Address:	Fax: