AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION B.07

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my child's health care provider: **Health First Family Medicine & Pediatrics** to use or disclose their health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my child's health care information to be released to the following recipient(s):

Name: **Morning Star Preparatory Academy**
Address: 1860 W. Parkway Blvd. West Valley City, UT. 84119

Purpose: I authorize the release of my child's health information for the following specific purpose:
To determine if there are any accommodations that need to be made in the student's classroom.

Information to be disclosed: Only the following records or types of health information:
Health Screening/Well Child Checkup obtained at Morning Star Preparatory Academy in the fall of 2023
I authorize the release of the following health information (please mark one):

- ❑ All records obtained during this visit
- ❑ Hearing & Vision Screening only
- ❑ None
- ❑ Other:_____

Term: I understand that this Authorization will remain in effect:

- ❑ Until the Provider fulfills this request or May 31, 2024

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my child's health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my child's health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my child's treatment at Health First. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Health First. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my child's health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____
Guardian/Parent Name (Please Print) Children Names

_____ _____
Guardian/ Parent Signature Date