

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Rick Scott**  
Governor

**John H. Armstrong, MD, FACS**  
State Surgeon General & Secretary

**Vision:** To be the **Healthiest State** in the Nation

**Florida Department of Health in Leon County**  
**CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION**

**School Year** \_\_\_\_\_

**Student's Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**School:** \_\_\_\_\_

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health in Leon County, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

**(Please check *and* initial all that apply)**

- \_\_\_  Leon County School District
- \_\_\_  Tallahassee Memorial Hospital Diabetes Center
- \_\_\_  Children's Medical Services  
(Name of case manager: \_\_\_\_\_)
- \_\_\_  Florida Department of Health in Leon County (Health Department)
- \_\_\_  Tallahassee Pediatric Foundation
- \_\_\_  Primary Physician \_\_\_\_\_  
(Please fill in Physician name)
- \_\_\_  Specialist Physician \_\_\_\_\_  
(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date