**SBHC -> School**

**Information Sharing Agreement**

**For Student Authorization**

The purpose of this information sharing agreement is to allow appointment information for _____(student/patient name) to be shared with _____ (school name) for the purpose of calling the student from class for school-based health center (SBHC) appointments with minimal disruption to their learning and for coordination of care.

By returning a signed copy of this agreement you (the student/patient) agree: 1) you are authorized to sign this agreement as a person aged 13 and older; 2) you provided consent to receive your SBHC treatment; and 3) your SBHC may share information about your confidential appointments at the SBHC, limited to date and time.

By signing this agreement, the school agrees to: 1) not disclose the SBHC appointment information to any person other than the school's attendance office staff.

You may terminate this agreement at any time by emailing [SCHOOL STAFF NAME] and [SCHOOL STAFF EMAIL

**By: _____**
**Student/Patient Name**

**By: _____** **Date: _____**
**Student/Patient Signature**

**By: _____**
**School Representative Name**

**By: _____** **Date: _____**
**School Representative Signature**