Authorization For Use of Disclosure of Health Information To Westfield Washington Schools

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization

Student's Name:____

Date of Birth:___________________ School Attending:_______________________________

I the undersigned do hereby request and authorize the following

_______________________________ ____
Physician Name Office Name

___________________________ ________________________
Contact Number Contact Fax

To provide health information to and from the above named child's medical record to:

School Contact Person:
Fax Number: Phone Number:
Address:
City: WESTFIELD State: INDIANA Zip code: 46074
Email address:____

The following items: (Please check all reports to be released)
_______ Medical Diagnosis
_______ Medication or prescription information
_______ Progress and Treatment
_______ Immunization Records
_______ Medical Records
_______ Recommendations
_______ Information deemed in the best educational interest and safety of the student
_______ Other____
The purpose of disclosure is:
_______ To comply with doctor referral or recommendation during school hours and activities
_______ Update of student Individual Health Care Plan
_______ Discontinuation of physician prescribed treatment while at school
_______ Update school nurse on student's emergency plan of action for school
_______ Update school health file

This authorization shall become effective immediately and shall remain in effect until ______ or for one year from the date of signature, if no date entered. Law prohibits the requestor from making further disclosure of my health information unless the requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance to this authorization. I understand that Westfield Washington schools will protect this information as prescribe the Family Equal Rights Protection Act (FERBA) and that the information becomes part of the student's educational record. I have the right to receive a copy of this Authorization. Signing this authorization may be required in order for the student to obtain appropriate services in the educational setting.

APPROVAL: __________________________ ________________________________ _________________
Printed Name Signature Date

____________________________ ___________________________________
Relation to student/patient Area Code and Telephone Number