

WEST IRONDEQUOIT CENTRAL SCHOOL DISTRICT

Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPPA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, \_\_\_\_\_ authorize my child’s healthcare provider(s) listed below:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

to release the medical records of my child \_\_\_\_\_ DOB \_\_\_\_\_

to the district’s Medical Director School Nurse Athletic Trainer (AT) Counselor Occupational  
Therapist (OT) Physical Therapist (PT) Psychologist Social Worker Speech Therapist (ST)

Other \_\_\_\_\_

The healthcare provider may disclose the following information: (Parent/School: check all that apply)

Immunizations Health Appraisals Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy Other \_\_\_\_\_

The Protected Health Information may be used, disclosed or received for the following purpose(s):

- To develop care or therapy plans for routine and emergent school management
- To design appropriate education, school or athletic programs
- To assess the impact of the medical condition(s) on school programming and/or attendance
- To share school observations/concerns surrounding behavior
- To assess a medical basis for modifications of transportation and/or home tutoring
- Medication delivery or therapy prescriptions
- At patient’s request with no specified purpose
- Other \_\_\_\_\_

Parent:

Choose one

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider’s office and to the District Administration Building. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of the Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child’s treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated avoid with the health care provider listed.

Parent/Guardian Signature

Relationship to student

Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION  
A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD