1 Marauder Boulevard
New York Mills, NY 13417

(315) 768-8129
FAX (315) 768-3396

Your child's school nurse will require the release of information form below to share Protected Medical information with school staff responsible for your child. Please complete, sign and return this form to the school nurse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I ____ authorize my child's healthcare provider(s) listed below, to release my child's ____ medical records and/or share information to medical officer, and/or school nurse and school staff responsible for my child in school:

Name: ________________________________ Phone: ________________ Fax: ________________

Name: ________________________________ Phone: ________________ Fax: ________________

Name: ________________________________ Phone: ________________ Fax: ________________

Name: ________________________________ Phone: ________________ Fax: ________________

The healthcare provider may disclose the following protected health information: (Check all that apply)

___ Immunizations ___ Health Appraisals

___ Past/Current Medical Condition, Impact on Attendance, School Programming, Therapy Needs

___ Other: ____

The Protected Health Information has been used, disclosed or received for the following purpose(s): (Check all that apply)

___ To develop care or therapy plans for routine and emergent school management

___ To design appropriate educational 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 modification of transportation and/or home tutoring

___ Medication delivery and/or therapy prescriptions for OT, PT, Speech

___ At patient's request with no specified purpose

___ Other: ____

Please select one: ___ This authorization is valid for the entire academic school year ___________

___ This authorization shall expire on ____________________(date)

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 the nurse at New York Mills Union Free School District.

I understand that the revocation of this authorization is not effective if the Healthcare Provider 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 this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand my child's treatment is not dependent on my agreement to release or withhold information.

____

Date Signature of Parent or Guardian Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the parent or guardian

This form goes ONLY to your School Nurse