



# Manchester-Shortsville Central School District

*“Red Jacket Schools”*

School Health Services

1506 Route 21, Shortsville, NY 14548-9502

Web Page: [www.redjacket.org](http://www.redjacket.org)

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## Authorization for Use or Disclosure of Protected Health Information

### COMPLETION OF THIS FORM IS VOLUNTARY

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 (HIPAA). 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  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, school programming, or therapy  Other \_\_\_\_\_

#### The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/School: check all that apply)

To develop care or therapy plans for routine and emergent school management  
 To design appropriate educational, 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 modification of transportation and/or home tutoring  
 Medication delivery or therapy prescriptions  
 At patient’s request with no specified purpose  
 Other \_\_\_\_\_

#### PARENT: Please select one.

This authorization is valid for the entire academic school year 20\_\_\_\_ - 20\_\_\_\_  
 This authorization is valid for the duration of attendance within the school district  
 This authorization shall expire on \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

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 School Nurse’s Office. 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 this 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 child’s healthcare providers. I give permission for the school representatives above to share and disclose information as indicated above with the healthcare provider listed.

Signature of Parent/Guardian or Student if over 18

Relationship

Date