FULTON AVENUE SCHOOL #8

3252 Fulton Avenue, Oceanside, New York 11572

"America's hope for the future passes through these doors"

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This form allows the providers designated below to share medical information concerning your child with the school district. This information will be used to allow health care collaboration to maintain student safety, provide care, or create/modify programming. Please sign and give this form to your healthcare provider and/or your school nurse

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider(s) **listed below**
(Parent/Guardian Name)

to share medical information of my child, _____, with the district's Physician, School Nurse, Occupational Therapist (OT), Physical Therapist (PT), Speech Therapist (ST), School Counselor, Psychologist, or the following individuals:

_____, _____, _____

List Health Care Providers (Physician, Dentist, Mental Health Care Provider)

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 and Impact on Attendance, Care at school or School Programming
- ☐ All of the above
- ☐ Other _____

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 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.

_____Date_____ Relationship_____
Signature of Patient (Over 18), Parent, or Guardian

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization should be given to the parent of the minor child/adult student over 18

/do
g:/nurse/medical release