WEST VALLEY CENTRAL SCHOOL DISTRICT

VERIFICATION OF CANCER SCREENING APPOINTMENT (Submit After Screening Appointment to the Business Office)

To be completed by Employee:

Employee Name: _____

Address: _____

_____

Telephone: _____

This is to verify that the above identified employee appeared

at: _____(Name of Facility)

on: _____ (Date)

at: _____(Time)

for the purpose of cancer screening.

To be completed by Screening Facility:

Name of person at facility who can verify appointment:

Printed Name: _____

Signature: _____

Telephone Number: _____

Physician Stamp:_____

WEST VALLEY CENTRAL SCHOOL DISTRICT

RELEASE FORM

TO BE COMPLETED BY EMPLOYEE:

I, _____(name of employee), hereby authorize _____(name of screening facility/health care provider) to disclose my protected health information (as more fully described below, for the purpose listed) to my employer, the West Valley Central School District.

The information to be disclosed consists of the date and time that I received cancer screening at the above-named screening facility/health care provider. This information will be used by the District to verify my right under applicable law to a leave of absence with pay from my duties for the purpose of such screening. **Nothing in this agreement authorizes the release of any information other than the date and time I received a cancer screening.**

This authorization is valid for _____(date) _____(time)

I understand that I may revoke this authorization at any time by sending written notice of the revocation directly to the screening/health care provider listed above; however, any revocation will be effective only to the extent that the screening facility/health care provider has not already disclosed my health information based on this authorization.

I understand that any information disclosed as a result of this authorization, once received by the District, may no longer be protected by the HIPAA Privacy Rule and may be subject to re-disclosure.

I understand that I am not required to sign this authorization. Any decision by me not to sign this authorization will not interfere with my ability to obtain health care from my health care provider(s), but could preclude me from receiving the paid leave as provided under CSL §159 b.

_____ _____

Employee Signature Date