



Rondout Valley

Central School District

Your healthcare provider will require this release of information form to share protected medical information with the school district. Please sign below to assist your school nurse in obtaining the information required by New York state for your child to attend school. If your child requires medication in school, please also sign the permission below.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider(s) listed below to release the medical records of my child, _____, to the district's medical officer and school nurse:

Name _____ Phone _____ FAX _____

Name _____ Phone _____ FAX _____

Name _____ Phone _____ FAX _____

The healthcare provider may disclose the following protected health information in order for my child to be in compliance with New York state mandated requirements for school attendance and medication administration in school:

- ☐ Immunizations
- ☐ Health Appraisals
- ☐ Medication Orders
- ☐ Other: _____

☐ This authorization is valid for my child's entire enrollment in the Rondout Valley Central School District.

☐ This authorization is valid until this 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 to the district's Central Registration 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.

Date

Signature of Parent or Guardian

Relationship

For medication and therapy administration in school:

I give permission for my child to receive medication or therapy as prescribed by my healthcare provider.

Date

Signature of Parent or Guardian

Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

This authorization will be placed in student's health record and a copy is available upon request.