Manchester-Shortsville CSD

1506 State Route 21, Shortsville, NY 14548

School Health Services

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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