

Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the _____ school, your healthcare provider may require the 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 school's: Principal School Nurse Occupational Therapist (OT) Physical Therapist (PT) Psychologist
Social Worker 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, 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 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
Medication delivery or therapy prescriptions
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 enrollment
This authorization shall expire on ___/___/___ (MO/DD/YR)

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. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

Signature of Parent/Guardian

Relationship

Date

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PARENT OF THE MINOR CHILD**