VICTOR CENTRAL SCHOOL DISTRICT

Since April 2003, HIPAA (Health Insurance Portability and Accountability Act) requires your healthcare provider to have the form below completed to share protected health information with the school district. Schools are required to have signed parent release under FERPA (Family Educational Records & Privacy Act). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

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, _____DOB_____, to the district's □ Medical Officer □ School Nurse, Occupational Therapist (OT), □ Physical Therapist (PT), □ Speech Therapist (ST), Athletic Trainer (AT), □ Psychologist, □ Social Worker, □ Counselor, □ other (specify) _____

Parent, list all your child's healthcare providers below:

Name_____ Phone_____ Fax_____

Name_____ Phone_____ Fax_____

Name _____ Phone_____ Fax _____

Name _____ Phone _____ Fax _____

The healthcare provider may disclose the following protected health information: (school and/or parent: check all that apply)

□ Immunizations

□ Health Appraisals

□ Past/Current Medical Condition and Its Impact on Attendance, Athletics, or School Programming or therapy(ies)

□ Other _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (school and/or parent: 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 (Note: if you do not sign for the complete academic year, you may need to complete another form, as needed):

□ This authorization is valid for the entire academic school year 20___-20_____

□ 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.

_____

Date Signature of Patient (Over 18), Parent, or Guardian Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD