GATES CHILI CSD AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your health care provider will require a release of information form to share Protected Medical Information with the school district. Please read and sign below.

I authorize my student's health care provider(s) listed below to release the medical records (including immunizations, health appraisals, and past/current medical conditions and their impact on attendance, school programming, and/or physical therapy, occupational therapy and/or speech therapy needs) of my student, whose name and date of birth are indicated below, to the school district's medical officer, physical/occupational/speech therapist, counselor, social worker, psychologist and/or school nurse.

Student Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____ **Relationship:** _____

Healthcare Provider 1: _____ **Phone:** _____

Healthcare Provider 2: _____ **Phone:** _____

Healthcare Provider 3: _____ **Phone:** _____

Healthcare Provider 4: _____ **Phone:** _____

The Protected Health Information may be used, disclosed, or received for the purposes of developing care or therapy plans for school management, designing appropriate educational programs, assessing school observations/concerns surrounding behavior and/or student health, assessing a medical basis for modification of transportation and/or tutoring (home or district-based), and medication delivery and/or therapy prescriptions for physical therapy, occupational therapy and/or speech therapy.

This authorization for release of information shall be in force and effect until no longer a student in the Gates Chili Central School District, at which time this authorization expires.

- I acknowledge that I have the right to revoke this authorization at any time by sending written notification to my health care provider and to the Gates Chili Administration Building.
- I understand that the revocation of this authorization is not effective if the health care provider or district has used the authorization for the disclosure of Protected Health Information before 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 may be subject to re-disclosure and may no longer be protected by federal or state law.
- I understand that my child's treatment, payment, enrollment or eligibility for benefits is not dependent on my agreement to release or withhold information.

Parent/Guardian Signature: _____ **Date:** _____ **Relationship:** _____

*********ONLY INITIAL BELOW IF REFUSING HIPAA*********

You may refuse to sign this authorization. Only initial and date below if you choose <u>not</u> to provide authorization.

Parent/Guardian Initials: _____ **Date:** _____