Fonda-Fultonville Central School
School Nurses' Office
112 Old Johnstown Rd.
P.O. Box 1501
Fonda, New York 12068-1501
Telephone: 518 853-3332 ext. 5010, 4226– Fax: 518 853-4426

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please 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 my child's_____ medical records to the district's medical officer, physical (PT), occupational (OT), speech therapists (ST) and/or school nurse:

Name_____Phone_____FAX_____
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____

The healthcare provider may disclose the following protected health information: (check all that apply)

☐ Immunizations
☐ Health Appraisals
☐ Past/Current Medical Condition and Its Impact on Attendance, School Programming, and/or PT, OT, ST needs
☐ Other_____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

☐ To develop care or therapy plans for routine and emergent school management
☐ To design appropriate educational 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 and/or therapy prescriptions for PT, OT, ST
☐ At patient's request with no specified purpose
☐ Other_____

Please select one:

☐ 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 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 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