Fonda-Fultonville
CENTRAL SCHOOL DISTRICT
A Legacy of Families First

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please complete the form and give the form to your health care provider and/or 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 medical officer, school nurse, physical (PT), occupational (OT), speech (ST) therapists:

Name:_____Phone#:_____ Fax#:_____
Name:_____Phone#:_____ Fax#:_____
Name:_____Phone#:_____ Fax#:_____

The health care provider may disclose the following protected health information (check all that apply)
__Immunizations
__Health Appraisals
__Current/Past Medical Conditions 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 educations programs
__To assess the impact of the medical condition 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 for no specific purpose
__Other_____

Please select one:
__This authorization is valid for the entire academic year 20___ - 20___
__This authorization shall expire on ___/____/20___

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my child's Health Care Provider's office and to the District 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 disclosure of the Protected Health Information before receiving any 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 state or federal law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

_____	_____	_____
Signature of patient (over 18) or parent/guardian	Relationship	Date

A signed copy of this authorization must be given to the adult patient or parent/guardian of the minor child.

Please contact the school nurses with questions or concerns, phone: 518-853-3332 ext. 5010; fax: 518-853-4426
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