AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (7240F.7)

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district or for the district to provide relevant information to your healthcare provider. Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

I, _____ authorize my child's healthcare provider(s) listed below
Parent/Guardian's name

to release the medical records of my child, _____, _____, to
child's name *date of birth*

the district's medical officer, physical (PT), occupational (OT), speech therapist (ST), counselor, social worker, psychologist and/or school nurse, or to the service provider(s) listed below.

HC Provider: _____ Phone_____ FAX_____
HC Provider: _____ Phone_____ FAX_____
HC Provider: _____ Phone_____ FAX_____
HC Provider: _____ 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
- ☐ All records
- ☐ Other (as listed): _____

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 school observations/concerns surrounding behavior
- ☐ To assess a medical basis for modification of transportation and/or tutoring (home or district-based)
- ☐ 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 as long as my child is enrolled in the district.
- ☐ This authorization is valid for the entire academic school year 20____-20_____
- ☐ This authorization shall expire on _____/_____/ _____ (MM/DD/YYYY)

I acknowledge that I have the right to revoke this authorization at any time by sending written notifications to the Privacy Officer at my healthcare provider's office and to the District Administration Building c/o the Director of Student Services.

I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for the disclosure of the 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 is not dependent on my agreement to release or withhold information.

Date	Signature of Parent/Guardian, Patient over 18	Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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

I give permission for my child to receive medication or therapy in school as prescribed by my healthcare provider.

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

Updated 03-2021