Since April 2003, HIPPA (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 a signed parent release under FERPA (Family Educational Records Privacy Act).

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, _____, to the district's □ medical officer, □ school nurse, □ Occupational Therapist (OT), □ Physical Therapist (PT),
□ Speech Therapist (ST), □ Athletic Trainer (AT), □ psychologist, □ social worker, □ counselor, or □ 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_____

This authorization is valid for the entire academic school career K-12.

I understand that I have the right to cancel (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 I may revoke this authorization, but a cancellation cannot apply to information already released in response to this authorization. If the recipient of information is not required to follow HIPAA regulations, shared information may be redisclosed 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, on a need-to-know basis with supervisory staff who will have responsibility for the welfare of my child, and when applicable with those governmental agencies as required for reimbursements.

_____ _____ _____

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