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 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 **Ripley Central School District's** medical officer, physical (PT), occupational (OT), and speech therapists (ST), School Psychologist, School Social Worker 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 Conditions and Its Impact on Attendance, School Programming, and/or PT, OT, ST, Psych Testing 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, Behavior or other medical conditions.
□ At patient's request with no specified purpose

□ Other _____

Please select one:

This authorization is valid for the entire academic school year 20___ - 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 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.

Signature of Parent/Guardian: _____

Relationship: _____

Date:_____