Brighton
CENTRAL ◆ SCHOOLS

SCHOOL HEALTH SERVICES
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student Name _____ Birthdate _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

I authorize my child's physician(s) and/or therapists listed above to exchange the following information with the school district staff listed below in order to provide a safe and appropriate environment/program for my child:

- ☐ School nurse
- ☐ Medical officer
- ☐ Physical Therapist
- ☐ Occupational Therapist
- ☐ Speech Therapist
- ☐ Athletic Trainer
- ☐ Counseling Department
- ☐ Special Education
- ☐ Psychologist
- ☐ Other _____

- ☐ Immunizations/Physical exams to comply with NYS regulations
- ☐ Care or therapy plans for routine and emergent school management
- ☐ Authorization for medications/treatment during school or on school trips
- ☐ Medical clearances as needed following an injury or change in condition
- ☐ Medical orders required for therapy needs, evaluations, programming
- ☐ Physician referral for services (OT, PT, ST, other)
- ☐ Medical condition that may have an impact in the school setting, including transportation, home tutoring, classroom accommodations, attendance
- ☐ At patient's request with no specified purpose
- ☐ Other _____

Parent, please select one (Note: if you limit time frame, you may need to complete another form in the future):

- ☐ 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 ____/_____/_____ (MO/DD/YR)

I acknowledge that I have the right to refuse to sign and to revoke this authorization at any time by sending written request to my healthcare provider and to the District Administration at the above address. I understand that if I revoke this authorization, it may not be effective if the Protected Health Information was already disclosed before receipt of 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 no longer be protected by federal or state law. I understand that my child's enrollment is not dependent on my agreement to release or withhold information, except immunizations required by law. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements pursuant to the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g) and implementing regulations (34 C.R.F. § 99). A copy of this release will be provided to me upon request. I understand that this form will be sent to the appropriate provider when requests are made, and I consent to the release of the information to the School District by the healthcare providers listed. If student is under 18 years of age, parent or legal guardian must sign consent form. If student is over 18 years of age and is a student with a disability as defined by the Individuals with Disabilities Education Act, then the parent/guardian must <u>also</u> sign consent form.

_____

Signature of Parent, or Guardian Relationship Date

_____

Signature of Student over 18 Date