Naples Central School District

Authorization for Use or Disclosure of Protected Health Information Form

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPPA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, _____, authorize my child's healthcare provider(s) listed below:
Name: _____ Phone #: _____ Fax #: _____
Name: _____ Phone #: _____ Fax #: _____
Name: _____ Phone #: _____ Fax #: _____

to release the medical records of my child, _____, DOB _____
to the district's:
- ▫ School Nurse
- ▫ Athletic Trainer (AT)
- ▫ Psychologist
- ▫ Counselor
- ▫ Speech Therapist (ST)
- ▫ Physical Therapist (PT)
- ▫ Social Worker
- ▫ Medical Director
- ▫ Director of Pupil Personnel Services
- ▫ Occupational Therapist (OT)
- ▫ Other _____

The healthcare provider may disclose the following information: (Parent/School: check all that apply)

- ▫ Past/Current Medical Conditions that have an impact on attendance, athletics, or school programming or therapy
- ▫ Immunizations
- ▫ Health Appraisals
- ▫ Other _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/School: 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
- ▫ At patient's request with no specified purpose
- ▫ Other _____

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PARENT: Please select one.

- ▫ This authorization is valid for the entire academic school year _____
- ▫ This authorization is valid for the duration of attendance within the school district
- ▫ This authorization shall expire on ____/____/____

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 and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child' 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 and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

_____

Signature of Parent/Guardian or Student (if over 18 years) Relationship Date

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 CHILD.