SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Permission for Release/Exchange of Student Records

Child's Name:_____ Date of Birth:_____
School: _____ Grade:_____

Your healthcare provider will require the release of information from below to share Protected Medical Information with Sahuarita Unified School District. Please sign and give the form to your healthcare provider and a copy 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 the district's medical officer, school nurse, physical (PT), occupational (OT), and/or speech therapists (ST):
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 condition and Its Impact on Attendance, School Programming, and/or PT, OT, ST 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 routing 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
__At patients request with no specified purpose
__Other _____

Please select one:
__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 revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the School Nurse.

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.

_____

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