Susquehanna Valley Central School District

This form allows the providers designated below to share medical information concerning your child with the school district. This information will be used to allow health care collaboration to maintain student safety, provide care, or create/modify programming. Please sign and give this form to your healthcare provider and/or your school nurse

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ________________________________ authorize my child's healthcare provider(s) **listed below**
(Parent/Guardian Name)

to share medical information of my child, ________________________________, with the district's Physician, School Nurse, Occupational Therapist (OT), Physical Therapist (PT), Speech Therapist (ST), School Counselor, Psychologist, or the following individuals:
__________________________,__________________________, __________________________

List Health Care Providers (Physician, Dentist, Mental Health Care Provider)

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 Condition and Impact on Attendance, Care at school or School Programming
☐ All of the above
☐ 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 assess the impact of the medical condition(s) on school programming and/or attendance in order to design appropriate educational programs

☐ 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
☐ All of the above
☐ Other____

Please select one:

☐ This authorization shall expire on my child's last date of enrollment at ________________________
☐ 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 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's treatment is not dependent on my agreement to release or withhold information.

____Date_______________ Relationship___________
Signature of Patient (Over 18), Parent, or Guardian

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization should be given to the parent of the minor child/adult student over 18