H.E. 630 (8/12)

CITY SCHOOL DISTRICT OF ALBANY
BUREAU OF HEALTH AND PHYSICAL EDUCATION

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your health care provider will require this form in order to share protected medical information with the City School District of Albany. Please complete this form, sign it, and give copies to your health care provider and the School Nurse as soon as possible.

I authorize the disclosure of my child's protected health information as described below. I understand that this authorization is voluntary and made to confirm my direction.
Parent: ____________________________ Child: _____________________________ Child's DOB: ________

Persons authorized to use or disclose information as specified below:

Health Care Provider	Address	Phone/Fax
		/
		/

Persons authorized to receive protected health information from the providers listed above:

School Personnel	Title	Address	Phone/Fax
			/
			/
			/
			/

Check below the information that may be disclosed:

- Health Appraisal
- Immunizations
- Recent Health History
- Medications
- Allergies
- Entire Record
- Lab Results: Type ______________________________________ Date ______
- X-Ray and Imaging Reports: Type ________________________ Date _______
- Consultation Reports: Consultant _____________________________________
  Consultant _____________________________________
- Other: Specify ____
- Recent Discharge Summary

The protected information may be used, disclosed, or received for the following purposes (check all that apply):

- Medication administration
- Therapy prescriptions for PT/OT/ST
- Participation in physical education/athletics
- To develop care/therapy plans
- To design appropriate educational programs
- To share school observations regarding behavior
- To address the impact of medical conditions on school programming and/or attendance
- To assess the medical basis for transportation and/or home tutoring
- Other: _________________________________
  ____

Please check one:

- This authorization is valid for the entire academic year 20___ to 20___.
- 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 health care provider's office and to the school administrator.

I understand that the revocation of this authorization is not effective if the health care provider or the District has used the authorization for disclosure of protected health information prior to receiving my written revocation notice.

I understand that information disclosed as a result of this authorization may be disclosed by the person or organization to which it is sent. I understand that it may not be possible to ensure my right to the protection of the privacy of this information once disclosed.

I understand that my child's treatment is not dependent upon my agreement to release or withhold information.

____ ________________________ ____________
Signature of Parent/Guardian or Student (Over 18) Relationship Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
A copy of this authorization must be given to the parent/guardian or to the student over 18 years of age.