Pearl River School District

135 West Crooked Hill Road
Pearl River, New York 10965
www.pearlriver.org
Phone: 845-620-3900

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please sign and return the form to the school nurse.

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, physical (PT), speech therapists (ST) and/or school nurse:

Name_____Phone_____FAX_____
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____

The healthcare provider may disclose, verbally and/or in writing, 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 routine and emergency 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 modifications of transportation and/or home tutoring
- ❑ Medication delivery and/or therapy prescriptions for PT, OT, ST
- ❑ At patient's 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 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 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 Signature of Patient (Over 18), Parent, or Guardian Relationship