SACKETS HARBOR CENTRAL HEALTH OFFICE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student Name _____ Birthdate _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

I hereby authorize my child's physician(s) listed above to exchange the following information with the following Sackets Harbor Central School staff :

- ☐ School Nurse
- ☐ Physical Therapist
- ☐ Occupational Therapist
- ☐ Speech Therapist
- ☐ Audiologist
- ☐ Vision Department
- ☐ Admissions officer
- ☐ School Psychologist
- ☐ School Social Worker
- ☐ _____
- ☐ Immunizations/physical exams to comply with NYS regulations
- ☐ Social History
- ☐ Psychological evaluations/reports
- ☐ Medical clearances as needed following an injury or change in condition
- ☐ Medical orders required for therapy needs; evaluations
- ☐ Authorization for medications during the school day or on school trips
- ☐ Medical condition/ treatment plans that may have an impact in the school environment
- ☐ Physician referral for services (OT, PT)
- ☐ Other _____

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon obtaining this release; however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. This release expires on the last day of the enrollment of the above student in school and may be revoked at any time by sending the request to cancel this permission in writing to the address above. Such revocation will not affect any disclosure made prior to its receipt. Protected health information will not be disclosed without consent per FERPA regulations. **A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made.**

☐ **I waive my right to receive a copy of this notice.**

_____ _____

(Signature of student over 18 or Parent/Guardian)** (Date)

**If a student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, authority to act on student's behalf: _____

This form complies with all HIPAA regulations. **Revised 3/2017**