HIPPA AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION TO AND FROM PINE VALLEY CENTRAL SCHOOL DISTRICT

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPPA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Student Name _____ _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize:

1. _____
[Your Doctor's Name]
Address:_____
Phone: _____
Contact: _____

2. _____
[Health Care Provider Name or hospital]
Address: _____
Phone: _____
Contact: _____

To provide health information from the above-named child's medical record to and from:

Pine Valley Central School 7755 Route 83, South Dayton, NY 14138-9698

School Nurses: Mrs. Hills, RN, MSN, SNT or Mrs. Pollock, RN {716} 988-3291 ext. 6 Elem. School
Mrs. Kenney, RN {716} 988-3276 High School

UPK Mrs. Cindy Press, Director, Jelly Roll Junction, 421 Rte 322, So. Dayton, NY 14138 988-7720

The disclosure of health information is required for the following purpose:

The exchange of health information between educational facilities and health care facilities and providers.

Requested information shall be limited to the following:

____ All minimum necessary health information: **OR**
____ Disease-specific information as described here: _____
_____

DURATION:

This authorization shall become effective immediately and shall remain in effect until (**circle one**) [HS graduation] or [enter date] or for one year from the date of signature, if no date is entered _____.

RESTRICTIONS:

Federal Law prohibits the Requestor [Pine Valley Central School District] from making further disclosure of my child's health information unless the Requestor [Pine Valley Central School District] obtains another authorization form from me [the parent/guardian] or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: ***I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My written revocation will be effective upon date of receipt.***

RE-DISCLOSURE:

I understand that the Requestor[Pine Valley Central School District] will protect this information as prescribed by the Family Educational Rights and Privacy Act [FERPA} and that information becomes part of the student's educational record. The information will be shared with individuals working at or with Pine Valley Central School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL: _____ _____ _____
Printed Name Parent/Guardian Parent/Guardian Signature Date

_____ _____
Relationship to student Phone Number