Wheatland-Chili Central School District

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Federal law, Health Insurance Portability and Accountability Act (HIPAA) requires that this form be complete before protected health information about your child can be exchanged between WCCSD and the child's health care provider.

Please read, sign, and date this form, and return to your child's school health official.

Child's Name_____ Child's date of birth:_____
Parent: _____ Parent: _____
Address: _____ Address: _____
City: _____ City: _____
State: _____ Zip: _____ State: _____ Zip: _____
Phone Number: (____) _____ - _____ Phone Number: (____) _____ - _____

HEALTH CARE PROVIDER:

Name: _____
Address: _____
Phone: (____) _____ - _____ Fax: (____) _____ - _____

Protected Health Information (check all that apply)

- ☐ Immunization
- ☐ Health Appraisals (i.e. physicals, evaluations)
- ☐ Past/current medical conditions
- ☐ Other _____
- ☐ Discharge Summary
- ☐ Service coordinator summary
- ☐ Behavioral data

Purpose: This protected health information may be used and/or disclosed for the purpose of: (check all that apply)

- ☐ To develop care of therapy plans for routine and emergency school management
- ☐ To design appropriate educational, school or athletic 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 modification of transportation and/or home tutoring
- ☐ Medication delivery
- ☐ Therapy prescriptions
- ☐ At patient/child's request
- ☐ Other, specify_____

Release to WCCSD Employees

The protected health information about your child may be disclosed to any of the following WCCSD personnel: medical officer, school physician, physical therapist, audiologist, psychologist, social worker, teacher of visually impaired, occupational therapist, nurse and/or speech therapist, or any other WSSCD representative working with your child.

Validity date: This authorization is valid for **(check one)**

- ☐ _____ through _____
- ☐ Will expire on _____

I understand:

- I may revoke this authorization at anytime by sending written notification to the privacy officer at my health care providers office and/or WCCSD, except where disclosure or action has been taken in reliance on this authorization.
- My child's treatment and/or enrollment is not conditioned on this authorization.
- WCCSD is an educational institution which may redisclose this information in accordance with the Family Educational Rights and Privacy Act (FERPA).

Authorization:

As the natural parent or legal guardian of the child, or as the non-minor student, I authorize the above health care provider(s) to disclose to WCCSD or receive from WCCSD the protected health information indicated above.

_____	_____	_____	_____
Parent(s) or legal guardian name	Relationship (if guardian)	Signature	Date

_____	_____	_____
If age 18 years or over, Student name	Signature, if age 18 years or over	Date