ST. AMBROSE ACADEMY
At Peace of Christ Parish
31 EMPIRE BLVD.
ROCHESTER, NY 14609
Phone 585-288-0580 Fax 585-288-2612

# Student Health Release Form

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

## 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 and/or school nurse:

Name _____ Phone _____ FAX _____
Name _____ Phone _____ FAX _____
Name _____ Phone _____ FAX _____
Name _____ Phone _____ FAX _____

The healthcare provider may disclose the following protected health information: (check all that apply)

- ☐ Immunizations
- ☐ Health Appraisals
- ☐ Past/current medical condition and its impact on attendance or school programming
- ☐ Other _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

- ☐ To develop care plans for routine and emergent 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 modification of transportation and/or home tutoring
- ☐ Medication delivery
- ☐ At patient's request with no specified purpose
- ☐ Other _____

Please select one:

- ☐ This authorization is valid throughout my child's enrollment in the school district
- ☐ 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 and regulations 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 |
|---|---|---|

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult patient or parent of the minor child