High Meadow School

Authorization for Use and Disclosure of Protected Health Information

In order to share protected health information with High Meadow School, your health care provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give this form to your healthcare provider and/or to your school nurse to avoid delays in the care of your child.

I, _____ authorize my child's healthcare provider(s) listed below:
Name: _____ Phone: _____ Fax: _____
Name: _____ Phone: _____ Fax: _____
Name: _____ Phone: _____ Fax: _____
To release the medical records of my child, _____ DOB: _____
To the school's designated: ☐ School Nurse, ☐ Occupational Therapist, ___ Physical Therapist
___Speech Therapist, ___ Other, Specify _____

The healthcare provider may disclose the following information: (Parent/School: check all that apply)
☐ Immunizations ☐ Health Appraisals ☐ Past/Current Medical Conditions and impacts on attendance, athletics, activities, school programming or therapy ☐ Other _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/School: Check all that apply)
☐ To develop care or therapy plans for routine and emergent 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 or transportation and/or home tutoring
☐ Medication delivery or therapy prescriptions
☐ At patient's request with no specified purpose
☐ Other _____

PARENT: Please select one of the following:
____ This authorization is valid for the duration of attendance at High Meadow School.
____ This authorization is valid for the time period: FROM _____ TO _____

I acknowledge that I have the right to revoke this authorization at any time by sending a written notification to the Privacy Officer at my healthcare provider's office and to High Meadow School. I understand that the revocation of this authorization is not effective if the healthcare provider or school 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. I acknowledge that High Meadow School or designee will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursement or by law. I give permission for the school representatives above to share and disclose information as indicated above with the health care providers listed.

_____

Signature of Parent/Guardian NAME (PRINTED) relationship Date