Lake George Elementary School

69 SUN VALLEY DRIVE LAKE GEORGE, NEW YORK 12845-3900
TELEPHONE 518-668-5714 FAX 518-668-5876
www.lkgeorge.org and twitter.com/jconwaylg

LYNNE RUTNIK
Superintendent of Schools
JAMES CONWAY
Elementary Principal

Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare 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 the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, _____ guardian for _____, DOB: ____/____/____ authorize the medical records of my child, to be released to the district from their healthcare provider and authorize the school district to share relevant school information with my healthcare providers.

Healthcare provider(s) listed below:

Name_____Phone_____Fax_____

Name_____Phone_____Fax_____

Name_____Phone_____Fax_____

The healthcare provider may disclose the following information:

* Immunizations * Health Appraisals
* Past/current medical conditions and its impact on attendance, athletics, school programming or therapy.
* Other_____

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

- 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 of transportation and/or home tutoring
- Medication delivery or therapy prescriptions
- At patient's request with no specified purpose
- Other_____

PARENT: Please select one.

❒ This authorization is valid for the duration of attendance within the school district

or

❒ This authorization is valid for the entire academic school year 20___- 20____

or

❒ This authorization shall expire on ____/_____/_____

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. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

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