ROCHESTER CITY SCHOOL DISTRICT
School Health Services
131 West Broad Street
Rochester, New York 14614

A Community of Learning

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (HIPAA)

Student Name _____ Birthdate: _____

Healthcare provider (doctor)_____ Phone: _____

Address _____ Fax: _____

Healthcare provider (doctor)_____ Phone: _____

Address _____ Fax: _____

☒ **Monroe County Health Dept. Clinics**

☒**Lead Testing** ☒**TB Clinic** ☒**Immunization Clinic** ☐**Other** _____

I hereby authorize my/my child's physician(s) listed above to exchange the following information with Rochester City School District, including:

☐ **All**

Or Specified:

☐ School nurse
☐ Medical officer
☐ Physical Therapist
☐ Occupational Therapist
☐ Speech Therapist
☐ Audiologist
☐ Vision Department
☐ Special Education
☐ Other _____

☐ Immunizations to comply with NYS regulations
☐ Physical exams to comply with NYS regulations and sports requirements
☐ Authorization for medications during the school day or on school trips
☐ Medical clearances as needed following an injury or change in condition
☐ Medical orders required for therapy needs, evaluations
☐ Physician referral for services (OT, PT)
☐ Medical condition/ treatment plans that may have an impact in school
☐ Other _____

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon signing this release, however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. Positive results on lead testing are shared on a need to know basis between the health services and the educational team to develop suitable programming to address any problems associated with high lead levels.

This release expires on the last day of the enrollment of the above student in the Rochester City School District, and may be revoked at any time by sending a written and signed request to cancel this permission to the address above. Such revocation will not affect any disclosure made prior to its receipt by the District. Protected health information will not be disclosed without consent pursuant to the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g) and implementing regulations (34 C.R.F. § 99). **A copy of this release has been provided to me. I understand that it will be sent to the appropriate provider when requests are made, and I consent to the release of the information to the Rochester City School District by the healthcare providers listed above.**

_____ _____

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

If student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, state authority to act on student's behalf: _____. If student is over 18 years of age and is a student with a disability as defined by the Individuals with Disabilities Education Act and the information requested pertains thereto, then the parent/guardian must <u>also</u> sign consent form.

<u>Return completed form to the NURSE at the school this child attends.</u>