Mount Vernon City Schools

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form allows the release of medical information to the school from the student's Physician/doctor.

Your healthcare provider will require Parent/Guardian signature on this form to share Protected Medical Information with the school district in relation to the student. Please sign and give the form to your healthcare provider and/or to the school nurse.

Student: _____ DOB: _____ Student ID: _____

Grade:_____ School: _____ Medical Agency: _____

I, _____ (Parent/Guardian) authorize my child's health care provider(s) to release (name of child) _____'s medical records to the school, specifically, the following person, persons, or agencies (school district, school nurse, physical therapist):

_____ _____

_____ _____

_____ _____

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

- □ Health Appraisals
- □ Immunizations
- □ Past/Current Medical Condition and Its Impact on Attendance, School Programming, and/or PT, OT, or ST needs
- □ Other _____

Please select one:

- □ This authorization is valid for the entire academic school year 20____ - 20____.
- □ This authorization shall expire on _____/_____/_____ (MO/DD/YR)

I understand that I am not required to sign this authorization and can refuse to sign it.
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 my child's treatment is not dependent on my agreement to release or withhold information.

_____ _____ _____

Date Signature of Parent or Guardian, or of Patient (Over 18) Relationship to Patient