TIEGERMAN Health Information Release Form

This form allows the providers designated below to share medical information concerning your child with TIEGERMAN. This information will be used to allow health care collaboration to maintain student safety, provide care, or create/modify programming. Please sign and return this form to your school nurse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider(s) **listed below**
(Parent/Guardian Name)

to share medical information of my child, _____, with the district's Physician, School Nurse, Occupational Therapist (OT), Physical Therapist (PT), Speech Therapist (ST), School Counselor, Psychologist, or the following individuals:

_____,_____, _____

List Health Care Providers (Physician, Dentist, Mental Health Care Provider)

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 Impact on Attendance, Care at school or School Programming
☐ All of the above
☐ Other _____

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

☐ To develop care or therapy plans for routine and emergent school management
☐ To assess the impact of the medical condition(s) on school programming and/or attendance in order to design appropriate educational programs

☐ 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
☐ All of the above
☐ Other_____

Please note:

☐ This authorization shall expire on my child's last date of enrollment at **TIEGERMAN**.

- 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_____ Relationship_____
Signature of Patient (Over 18), Parent, or Guardian

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION