Marion Central School
Jr. Sr. High School

Donald Bavis
Superintendent

Shane Dehn
Principal

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider(s) listed below to release medical records for my child_____ to the district's Medical Practitioner, School Nurse, Occupational Therapist, Physical Therapist, Speech Therapist, School Counselor, School Psychologist, School Social Worker or other (specify):_____

Parent, list all your child's healthcare providers that pertains to above:

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 [ ] Other_____

[ ] Past/Current Medical Conditions(s) and its impact on attendance or school programming.

**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 programs

[ ] To assess the impact of the medical conditions(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 specific purpose

[ ] Other_____

**Please Select One:

[ ] This authorization is valid for the academic year 20___ -20___

[ ] Thus authorization shall expire on ___/___/___ (MO/DD/YR)

I acknowledge that I have the right to revoke this Authorization at any time by sending written notification to Marion Central and to the Healthcare Providers listed. I realize that information provided before a written revocation is in hand does not apply to this revocation. 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 state and federal law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I understand my right to refuse to sign this Authorization.

Date:_____Parent/Guardian Signature_____Relationship:_____