Altmar-Parish-Williamstown Central School District
639 County Route 22, Parish, NY 13131
Phone: 315-625-5223 Fax: 315-625-4278

HIPPA-COMPLIANT AUTHORIZATION FOR EXCHANGE OF HEALTH AND/OR EDUCATIONAL INFORMATION

PATIENT / STUDENT INFORMATION

Patient's Name: _____ Date of Birth: _____

I hereby authorize the following doctors:

Doctor's Name: _____ Phone: _____

Doctor's Name: _____ Phone: _____

To release ☐ To obtain ☐ my child's health information/records for the purposes listed below to:

Altmar-Parish-Williamstown Central School District

Name: _____

Building _____

Description	☐ Medical and/or related health records.
The health information to be disclosed consists of:	☐ Psychological evaluations behavioral assessments and/or social work reports.
	☐ Appropriate agency reports (if any)

The Education Information to be Disclosed Consists of (describe educational information)**:**_____

Purpose: This Information will be used for the following purposes:

1. Educational evaluation and program planning.
2. Health assessment and planning for health care services and treatment in school.
3. Medical evaluation and treatment.
4. Other: Provide other information if applicable

Authorization: This authorization is valid from September 1, _____ to September 1, _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Patient / Guardian Signature: _____ Date Signed: _____

Student Signature:* _____ Date Signed: _____

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form.

Copies:

- ☐ **Parent or Student***
- ☐ **Physician or Other Health Care Provider Releasing the Protected Health Information.**
- ☐ **School Official Requesting/Receiving the Protected Health Information.**