

Laurens Central School

“A Community Center”

P. O. Box 301
Laurens, New York 13796
Telephone (607)432-2050
Fax (607)432-4388

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student Name _____ Birthdate _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

I hereby authorize my child's physician(s) listed above to exchange the following information with Laurens Central School staff, including:

- | | |
|---|---|
| <input type="checkbox"/> School Nurse | <input type="checkbox"/> Immunizations/physical exams to comply with NYS regulations |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Psychological evaluations/reports |
| <input type="checkbox"/> Speech Therapist | <input type="checkbox"/> Medical clearances as needed following an injury or change in condition |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Medical orders required for therapy needs; evaluations |
| <input type="checkbox"/> Vision Department | <input type="checkbox"/> Authorization for medications during the school day or on school trips |
| <input type="checkbox"/> Admissions officer | <input type="checkbox"/> Medical condition/ treatment plans that may have an impact in the school environment |
| <input type="checkbox"/> School Psychologist | <input type="checkbox"/> Physician referral for services (OT, PT) |
| <input type="checkbox"/> School Social Worker | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> _____ | |

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 obtaining 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. This release expires on the last day of the enrollment of the above student in school and may be revoked at any time by sending the request to cancel this permission in writing to the address above. Such revocation will not affect any disclosure made prior to its receipt. Protected health information will not be disclosed without consent per FERPA regulations. **A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made.**

I waive my right to receive a copy of this notice.

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

(Date)

**If a student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, authority to act on student's behalf: _____

This form complies with all HIPAA regulations.

Revised 1.07 KM