

KEENE CENTRAL SCHOOL

33 Market St., P.O. Box 67, Keene Valley, NY 12943 (518) 576-4555 Fax (518) 576-4599 www.keenecentralschool.org

ADMINISTRATION

Cynthia Ford-Johnston, *Superintendent*
Jatha E. Miner, *School Counselor*
Harry B. Fine, *Dean of Students*
Brenda L. Le Clair, *District Treasurer*
Susan Whitney, *District Clerk*

BOARD OF EDUCATION

Teresa Cheetham-Palen, *President*
Kathy Smith, *Vice President*
Jim Giglinto
James Marlatt
Ann Whitney

HIPPA Form

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider(s) listed below to release my child's _____ medical records to the district's school nurse, physical (PT), occupational (OT), and/or speech therapist (ST) :

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 Appraisal
- Other
- Past/Current medical condition and its impact on attendance, school programming, and/or PT, OT, ST needs

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 design appropriate educational programs
- To assess the impact of the medical condition(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 and/or therapy prescriptions for PT, OT, ST
- At patients request with no specified purpose
- Other _____

Please select one:

- This authorization is valid for the entire academic school year 2008-2009
- This 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 the Privacy Officer at my healthcare provider's office and to the school nurse at Keene Central School District.

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 states and federal privacy laws 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	Signature of Patient (Over 18), Parent, or Guardian	Relationship
------	---	--------------

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult patient or parent of the minor child

