Standard Authorization for the Exchange of Health Information

This form authorizes the exchange of protected health information (PHI) and education records (including personally-identifiable information obtained therefrom) between your child's health care provider and authorized school officials.

Student's Name: _____ **DOB:** _____
Address: _____
(Street, City, State, Zip Code)

Description of the documents and information to be disclosed:

- Documentation mandated by the New York State Education Department.
  - Pre-participation history and physical examinations for athletics
  - Mandated health history and physical examinations
  - Return to school post injury or illness and medical documentation of permissible activity
  - Immunizations
  - Medications administered to or by a child at school
  - Academic performance information, if relevant to medical condition(s)
  - Therapy services (OT, PT, ST) being provided to the student
- Documentation related to accommodations requested/required for asthma, concussions, or other medical conditions

*This release does not apply to mental health, alcohol/drug, HIV or other information which by law cannot be released without specific authorization.

Information is to be disclosed **BETWEEN**:

_____
(Name and address of student's physician or other provider)

and **ITHACA CITY SCHOOL DISTRICT** (ICSD), and school physician(s) and nursing staff at the school the child attends.

It is necessary for ICSD to share health information with the student's health care providers to facilitate and promote informed recommendations and decision-making by both the health care provider and school district with respect to the student's educational program. This release authorizes disclosure of the records described above and personally-identifiable information obtained therefrom) by ICSD to the student's heath care providers for the following purposes:

- To comply with a request from the student's parent/person in parental relation and/or legal guardian, or the student (if age 18 or older and competent);
- To assist with an evaluation or the provisions of services by ICSD
- To coordinate the provision of medical services;
- Other (please specify): _____

This authorization shall remain valid until either (*initial one*):
☐ The student is no longer a student of ICSD; or ☐ Other specified date or event: _____

Acknowledgments:
I hereby, knowingly, and voluntarily authorize the above-named agency/provider to use or disclose this information only in the manner described above. I understand treatment, payment, and health plan enrollment will not be conditioned on my authorization of this disclosure. I understand that I may revoke this authorization in writing at any time.

_____ _____
PARENT/GUARDIAN SIGNATURE **Date signed:**

_____ _____
Printed name of parent/guardian **Relationship to student**