AUTHORIZATION FOR USE **OR** DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO SCHOOL **OR** DAYCARE

I, ____authorize Tonawanda Pediatrics/Island Pediatrics to release my child ____________________________ ‘s medical records to the district's health and/or administrative personnel and/or daycare provider. The following protected health information may be disclosed:

(Check all that apply)

- θ Immunizations
- θ Health Appraisals
- θ Past/Current Medical Condition and its impact on school/daycare attendance, school programming, and/or PT, OT, ST needs
- θ Medical Administration
- θ Sports Participation
- θ Other

The Protected Health Information may be used, disclosed or received for the following purpose(s):

(Check all that apply)

- θ For compliance with school/daycare requirements
- θ To develop care or therapy plans for routine and emergent school/daycare management
- θ To design appropriate educational programs
- θ To assess the impact of the medical condition(s) on school/daycare attendance and/or programming
- θ To share school/daycare observations/concerns surrounding behavior
- θ To assess a medical basis for modification of transportation and/or home tutoring
- θ To assess the ability to participate in physical education/sports
- θ Medication delivery and/or therapy prescriptions for PT, OT, ST
- θ At parent's/patient's request with no specified purpose
- θ Other

Please select one:

- θ This authorization is valid for the entire academic school year 20 ____ -20____.
- θ This authorization shall expire on ___/___/___(MO/DA/YR).

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to:
Tonawanda Pediatrics, Attn: Privacy Officer, 3950 East Robinson Rd., West Amherst, NY 14228. 716-691-3400.

I understand that the revocation of this authorization is not effective if Tonawanda Pediatrics/Island Pediatrics 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 state and federal privacy laws may be subject to redisclosure 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.

____ ____
Signature of Patient (over 18), Parent, or Guardian Relationship

____
Date YOU MAY REFUSE TO SIGN THIS AUTHORIZATION