Integrity Health Group

School/Daycare Authorization

I,_____authorize Integrity Health Group to release my Child_____DOB_____'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)

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

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

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

Please select one:

- ❑ This authorization is valid for the entire academic school year 20____-20____
- ❑ 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:

Integrity Health Group, Attn: Office Manager, 3950 East Robinson Rd., Suite 205, West Amherst, NY 14228.

I understand that the revocation of this authorization is not effective if Integrity Health Group 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