**APPENDIX B**

**AUTHORIZATION FOR USE OF DISCLUSURE OF HEALTH INFORMATION TO AND FROM SCHOOL DISTRICTS**

Completion of this document authorizes the disclosure and/or use of the individually identifiable Health information, as set forth below, consistent with Federal Laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

**USE AND DISCLOSURE INFORMATION**:

Patient/Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST MIDDLE MI Date of Birth

I the undersigned do hereby authorize (name of agency and/or health care providers):

1. **Roberta Dennison, MD or School Physician** (2) **77 Salem Street – Malden, MA 02148**

To provide health information from the above named child’s medical record to and from

Malden Public Schools 77 Salem Street – Malden, MA 02148

***School District to which disclosure is made Address/City/State/Zip Code***

Jen Sturtevant, Athletic Trainer or Charlie Conefrey, Athletic Director 781-397-6006/6007

***Contact Person at School District Telephone Number***

The disclosure of health information is required for the following purpose:

Participation in the school athletic program

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Requested information shall be limited to the following: All minimum necessary health information; or Disease-specific information as described:

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**DURATION**:

This authorization shall become effective immediately and shall remain in effect until\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(enter date) or from one date of signature, if no date is entered.

**RESTRICTIONS**:

Law prohibits the Requester from making further disclosure of my health information unless the Requester obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

**YOUR RIGHTS**:

I understand that I have the following rights with respect to this authorization: I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be in effect upon receipt, but will not be effective to the extent this Requestor or others have acted in reliance to this Authorization.

**RE-DISCLOSURE**:

I understand that the Requester (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student’s educational record. The information will be shared with the individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and the school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

**APPROVAL**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

*Printed Name Signature Date*

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*Relationship to Patient/Student Telephone Number*