Camden Central Schools

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

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 medical officer, physical (PT), occupational (OT), speech therapists (ST) and/or school nurse:

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 Appraisals
☐ Past/Current Medical Condition and Its Impact on Attendance, School Programming, and/or PT, OT, ST needs
☐ Other_____

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 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/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 District Administration Building.

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 state 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

Camden Central School District
51 Third Street
Camden, NY 13316

CONSENT FOR RELEASE OF RECORDS

☐	Camden High School 55 Oswego St., Camden, NY 13316	Phone: (315) 245-3168	Fax: (315) 245-4173
☐	Camden Middle School 32 Union St., Camden, NY 13316	Phone: (315) 245-0080	Fax: (315) 245-4094
☐	Camden Elementary 1 Oswego St., Camden, NY 13316	Phone: (315) 245-2616	Fax: (315) 245-4194
☐	Annsville Elementary Main St., Taberg, NY 13471	Phone: (315) 334-8030	Fax: (315) 334-8032
☐	McConnellsville Elementary 8564 State Route 13, Blossvale, NY 13308	Phone: (315) 245-3412	Fax: (315) 245-4193
☐	North Bay Elementary 2050 State Route 49 P.O. Box 257 North Bay, NY 13123-0257	Phone: (315) 245-2640	Fax: (315) 245-4191

STUDENT: _____ **DOB:** _____

RECORDS TO BE RELEASED INCLUDE (but are not limited to):

_____ Permanent Record Information: transcripts and credits received, copy of birth certificate (For H.S.- transcript to include all current/sign-out grades and credits)

_____ Education Records: report cards, standardized tests, projected schedules/records and transcripts from prior schools attended/remediation program information (For H.S.- completed labs for any regents science lab classes)

_____ Health Records: immunization/wellness records/records of student physical/sports physical/doctor imposed restrictions/psychological reports, other records as requested by your health care provider

_____ CSE File Information (if applicable): IEP, Evaluations, Reports, Consent Forms

_____ Results of New Entrant Screening as mandated by NYS Education Law

_____ Disciplinary/Attendance Records (especially serious/repetitive infractions) TO INCLUDE BEHAVIORAL REFERRALS

_____ Parent Contact Summary: custody paperwork/custody issues/orders of protection/etc.

_____ Other: ALL PERTINENT DATA RELATIVE TO THE ABOVE NAMED STUDENT

I understand that information to be released will be maintained by the receiving agency/person in accordance with the provisions of the Family Education Rights and Privacy Act of 1974 (and successor Laws). Such information will be used only in the best interests of the child and for the purpose of planning an educational program for the child.

RECORDS TO BE RELEASED TO: _____

_____

_____

Phone: _____ Fax: _____

➢ **Signature** _____ Date _____ Relationship _____