# **HEALTH SERVICES**

# Linda Roscoe-Perkovac, RN

# Director

(520) 269-4510 • FAX (520) 269-4513

lperkovac@amphi.com



 Deanna M. Day, M.Ed. Vicki Cox Golder Scott K. Baker, Ph.D. Matthew A. Kopec Susan Zibrat

 President Vice President

Governing Board Members

 701 W. Wetmore Road • Tucson, AZ 85705 • (520) 696-5000 • www.amphi.com

Superintendent

Todd A. Jaeger, J.D.

# Authorization for Use or Disclosure of Protected Health Information

**Student**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**School/Grade**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Requested From:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of MD, Agency, Hospital Fax #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address City State Zip

**Amphitheater Public Schools**

**701 W. Wetmore Rd.**

**Tucson, AZ 85705**

**520-269-4511, FAX 520-269-4513**

 **Requested By:**

**□ Linda Roscoe-Perkovac, RN - Director of Health Services**

**□ Lauren Andersen, RN, MSN - Amphitheater Nurse Case Manager**

**Purpose of Use/Disclosure:** Students with special health care needs require an IHP (Individualized Health Care Plan) to address their medical/safety needs during their school day. Therefore, a review of medical information is required.

**Medical Information Requested □ Written □ Verbal □ Written and Verbal**

□ Initial History □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ All health information pertaining to my child’s medical history, mental or physical condition and treatments received.

 Dated from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 EXCEPT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expiration:** This authorization expires (date/event):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Restrictions:** The Governing Board of Amphitheater Public Schools has established written procedures/policies regarding the use of collected health information to ensure the confidentiality of the information and to guarantee parents and students rights to privacy. These policies and procedures are in compliance with the Family Educational Rights and Privacy Act (FERPA), Title 20, etc.

**Assurance Signature:** In making this request, the undersigned agrees that the information received will be used only by the professional school staff members who are assigned to work with the student in the educational program and will not be released to any other party without the prior written consent of the parent.

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 Date Requested Authorized Signature

**Rights:** I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf. My revocation will be effective upon receipt, but will not be effective to the extent that the Requesting Party has already requested and/or received the authorized health information.

**Parent/Guardian:** I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as parent of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Name) (Student Name)

 consent to the release of protected health information listed above to the party named above. I am aware of my rights to review the records and receive a copy, at my expense, if I so request.

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