Pulaski Academy & Central School District

Pulaski, New York 13142

Authorization for Exchange of Health and/or Educational Information

Patient/Student Name: _____ **DOB:** _____

I hereby authorize the following doctors:

Healthcare Provider's Name _____ Phone# _____
Healthcare Provider's Name _____ Phone# _____
Healthcare Provider's Name _____ Phone# _____
Healthcare Provider's Name _____ Phone# _____
Healthcare Provider's Name _____ Phone# _____

to release ○ obtain ○ my child's health information/records for the purpose listed below to/from:

Name: _____ of the **Pulaski Academy and Central School District**

Description:
The health information to be disclosed consists of:

○ Medical and/or related health records

○ Psychological evaluations, behavioral assessments, and/or social work reports

○ Appropriate agency reports (if any)

The Education Information to be disclosed consists of:
Describe Educational Information: _____

_____

Purpose: This information will be used for the following purpose(s)?
1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school
3. Medical evaluation and treatment
4. Other: Provide Other Information Below (if applicable) _____

_____

Authorization
This authorization is valid from the date of signature through June 30th of the current school year. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____ _____
Parent Signature Date

_____ _____
Student Signature* Date

* If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form.