HAVERHILL PUBLIC SCHOOLS

REQUEST AND AUTHORIZATION FOR RELEASE OF HEALTH CARE RECORDS

Purpose: Your child has been identified as having a possible health/psychological/educational need. The purpose of this form is to allow Haverhill Public Schools to obtain health care records that will be used in establishing an appropriate plan of care and possible future educational services for your child. As a parent/guardian, you have the right to give or not give permission for the release of your child's health care records. Please fill out the shaded portions of this form and send the form to your child's health care provider.

Student Name: _____ Date: _____
Student DOB: _____ School District: **Haverhill Public Schools**

I hereby authorize the release of records:

From: _____ To: Doreen Swartz RN, BSN.
Name of health care provider *Name of school and personnel*
_____ 150 Boardman Street
Street address *Street address*
_____ *Haverhill, MA 01830*
City, State, Zip *City, State, Zip*

Please fax the records to this fax number: __978-374-3441_____.

General Medical Information to be Disclosed (check):

- o Medical and Clinical Records
- o Social/Emotional Evaluation
- o Immunization Records
- o Vision/Hearing Evaluation
- o Psychological Evaluation
- o Speech/Language Evaluation
- o Occupational/Physical Therapy Evaluation

Specific Authorizations: This consent ☐ does ☐ does not allow for the release of specific information as indicated below:

☐ Mental Health/Psychiatric Care ☐ HIV (AIDS) Testing/Diagnosis/Treatment

☐ Drug and Alcohol Abuse Diagnosis or Treatment ☐ Confirmed STD Test Results and/or Treatment

I understand that the state law protects any records that contain information regarding mental health; drug/alcohol abuse or treatment records are protected under federal confidentiality laws (42 CFR 2); HIV/AIDS (or) confirmed STD tests or treatment records are protected by state confidentiality laws(603 CMR 23.00).

Your signature below means you understand and agree to the following:

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party.

I understand that (a) I must revoke my authorization in writing and may do so by completing and signing a revocation of authorization form with my health care provider; and (b) if I revoke my authorization, I understand that it will not affect any actions already taken by the health care provider based on this authorization.

Information disclosed under this authorization may be redisclosed by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Records received by the Haverhill Public Schools, however, are protected from redisclosure under the Family Education Rights to Privacy Act (FERPA).

NOTE: Authorizations for release of medical records are valid for no longer than 1 year unless otherwise specified above. If a date range is not provided, the authorization expires 1 year from the date this authorization is signed

I understand that my consent for the release of records is voluntary and that I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under this authorization/release.

_____ _____ _____
Date Signature of patient's parent/guardian Relationship to patient

_____ _____
Date Signature of patient/student if applicable