Syracuse City School District

SYRACUSE CITY SCHOOL DISTRICT

Health Services
725 Harrison Street · Syracuse, NY 13210
Phone 315·435·4145 · Fax 315·435·4859

Jaime Alicea
Interim Superintendent of Schools

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO SCHOOLS

Student Name: _____ DOB: _____ Date: _____

As the parent/guardian of the child named, the completion of this form authorizes your doctor, _____ to disclose your child's confidential health-related information to his or her school.
(name of MD)
The purpose for disclosing this information is to promote the accurate exchange of health information and for the coordination of care and treatment with the child's school. This is important information for many reasons. For example the school may need to know this information in order to give medications, monitor the child's illness, and keep track of immunizations.

This authorization limits the disclosure of information to the following:

- ☐ Immunization information
- ☐ Physical exam reports
- ☐ Laboratory tests
- ☐ Medications and treatments

This authorization form does not allow the disclosure of confidential health information that is given special protection under the law. This includes HIV-related information, substance abuse information, psychiatric information and genetic information; the disclosure of this information requires a different specific form.

The information will be disclosed to the school in the school district indicated below until you tell us that the child is no longer an enrolled student at the school. You may revoke this authorization at any time by notifying the child's healthcare provider in writing. Revoking this authorization means that we will no longer disclose the child's information to their school. The child's healthcare will not be affected if you do not authorize us to disclose their information to the school. In other words, we will not refuse your child treatment if you do not sign this authorization. The information we disclose to the school may be redisclosed to others by the school if the school is not required under law to protect the confidentiality of this information. You will be given a copy of this completed authorization to keep for your records.

Child's Name (print)	Date of Birth
Parent/Guardian's Name (print)	Relationship
Parent/Guardian's Signature	School

Please return to School Nurse.