TURKEYFOOT VALLEY AREA SCHOOL DISTRICT

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION EFFECTIVE FOR PATIENT REQUESTS ON OR AFTER APRIL 14, 2003 (45 C.F.R. 164.508)

I authorize____

Name of Health Care Provider/Entity

To use and disclose a copy of the specific health and medical information about

________________________________ , a minor.

(Name of Child)

Name of Recipient: Jeffrey S. Malaspino, Superintendent or his/ her official designee, TVASD, 172 Turkeyfoot Road, Confluence, PA 15424.
Purpose of Disclosure: confirming need for homebound instruction
Information to be used/disclosed: documentation/information and/or diagnoses confirming the student is physically unable to attend school.
Date of service to be disclosed:
This Authorization will expire on upon student's return to school and/or within 180 days

Expiration Date/Defined Event

We are requesting this Authorization from you for our own use to allow a health care provider to disclose information to us.

This release authorizes the District to communicate with the student's doctor to verify that the doctor recommends homebound instruction.

- We will condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed; **PLEASE NOTE, however that the physician's office and/or facility (hospital) where the services were provided is the sole custodian of your original medical record;**
- You may refuse to sign this Authorization;
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. However, doing so may cease instructional services.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Signature of Parent/Patient:____

Please Print Name:____**Date:**_______________________
Personal Representative (if applicable):
Relationship to the patient: