SYRACUSE CITY SCHOOL DISTRICT

Pamela J. Odom, Superintendent of Schools

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO SCHOOLS

Please sign this so that we may get health information from your child's doctor.

Student Name: _____ DOB: _____ Date: _____

As the parent/guardian of the student named, the completion of this form authorizes your doctor to disclose your student's confidential health-related information to his or her school.
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 student's school. This is important information for many reasons. For example, the school may need to know this information to give medications, monitor the student's illness, and keep track of immunizations.

Provider/Practice Name: _____

Address: _____ Phone Number: _____

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 student is no longer an enrolled student at the school. You may revoke this authorization at any time by notifying the student's healthcare provider in writing. Revoking this authorization means that we will no longer disclose the student's information to their school. The students' 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 student 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. Please keep a copy for your records.

_____ _____

Student's Name (print) Date of Birth

_____ _____

Parent/Guardian's Name (print) Relationship

_____ _____

Parent/Guardian's Signature School

PLEASE RETURN TO THE SCHOOL NURSE