HOPEWELL AREA SCHOOL DISTRICT
MEDICAL INFORMATION AUTHORIZATION FORM

Hopewell Senior High	724-378-8565	Fax: 724-378-4952
Hopewell Junior High	724-375-7765	Fax: 724-378-2594
Hopewell Elementary	724-375-1111	Fax: 724-375-4729
Margaret Ross Elementary	724-375-2956	Fax: 724-378-8555
Independence Elementary	724-375-3201	Fax: 724-375-5141

In order to comply with federal and state laws the Hopewell Area School District requires that this form be completed in its entirety.

I authorize the school nurses of the Hopewell Area School District to use / disclose the following Protected Health Information from the records of:

Student Name

as described below: **Any other HASD teacher or staff member, including substitutes, building principals and secretaries who may be responsible for my child.**

This information is requested for the purpose of: **To inform any such staff member or administrator who may be responsible for my child of any serious medical conditions, allergies, medications and/or emergency contacts.**

The information to be used / disclosed is identified as follows (please check all that apply):

_____Medical history & physical exams	_____Psychiatric/Psychological evaluation
_____Occupational therapy	_____Physical therapy
_____IEP	_____ERs
_____Discharge summary instructions	_____Immunization records
_____Physician orders	_____Verbal information

__X__Other (please specify): **Any health information appearing on the Student Health History Information Form submitted to the school nurse regarding serious medical needs/conditions, allergies, medications or health insurance.**

This authorization expires: upon graduation

I understand the following:

- **That the information used or disclosed may include records relating to my identity, diagnosis, prognosis and treatment;**

- **That the information used or disclosed may relate to psychiatric disorders, drug and/or alcohol use, AIDS and HIV, as the same are permitted by the Mental Health Procedures Act, the Confidentiality of Alcohol and Drug Abuse Individual Records Act, the Confidentiality of HIV-Related Information Act and the Privacy Rule of the Health Insurance Portability and Accountability Act;**

- **That I have the right to revoke this authorization at any time, except to the extent that Hopewell Area School District has already acted in reliance on the Authorization and that such revocation must be made in writing and directed to the Privacy Officer, the district Superintendent;**

- **That the information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law;**

- **That Hopewell Area School District may not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this Authorization, except as provided by law; and**

- **That if the Hopewell Area School District seeks this Authorization for the use or disclosure of Protected Health Information, the district must provide me with a copy of the signed Authorization.**

_____ _____

Date Signature of Parent/Legal Guardian/Personal Representative

_____

Print Name

_____

Specify Relationship / Authority