



CITY SCHOOL DISTRICT OF NEW ROCHELLE  
 515 NORTH AVENUE  
 NEW ROCHELLE, NEW YORK 10801-3416

**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION**

**Student Name** \_\_\_\_\_ **DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Guardian Name** \_\_\_\_\_  
LAST NAME, FIRST NAME LAST NAME, FIRST NAME

**Student Grade** \_\_\_\_\_ **School:** \_\_\_\_\_

**Employee Name** \_\_\_\_\_ **Assigned Building /**  
LAST NAME, FIRST NAME **Work Location:** \_\_\_\_\_

I hereby authorize the use and disclosure of the protected health information as described below. I understand that this authorization is voluntary.

For Students: Protected health information released to the School District pursuant to this authorization becomes a part of the student's education record. Under the Family Educational Rights and Privacy Act (FERPA), information in a student's education record can be disclosed to appropriate school personnel who have a legitimate educational interest in reviewing the record. It cannot be released to persons outside of the School District without express written consent, except as permitted by FERPA.

Information to be released: \_\_\_\_\_

Records pertaining to admission of date(s): \_\_\_\_\_  
MONTH YEAR

and or treatment/visit on date(s) \_\_\_\_\_  
MONTH YEAR

at (Hospital/Office/Location) \_\_\_\_\_  
NAME OF HOSPITAL / PHYSICIAN OFFICE TELEPHONE FAX

\_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE

**INFORMATION**

- Immunization Record
- Inpatient Record
- Outpatient Record/Emergency Room
- Ambulatory Surgery
- MD/Specialist Summary/Consult
- Discharge Summary
- Operative Report
- Lab Results
- Pathology/Radiology/Imaging Reports (circle which)
- Evaluation - Type(s) \_\_\_\_\_
- Other - Specify \_\_\_\_\_

**DATE(S):**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Disclosure related to Psychiatric Care, Alcohol & Drug Abuse and HIV/AIDS will be released only if you initial the applicable box:

- Psychiatric Services
- Alcohol & Drug Abuse
- HIV/AIDS

[Separate NYS Department of Health authorization is also required.]

STUDENT/EMPLOYEE NAME: \_\_\_\_\_  
LAST NAME, FIRST NAME

Persons within the City School District of New Rochelle who will receive the information:

\_\_\_\_\_  
\_\_\_\_\_

Send Information to: Name: \_\_\_\_\_

Address: \_\_\_\_\_

New Rochelle, New York 1080 \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Purpose/Use of Disclosed Information:**

- Health Office: Review of Immunizations
- Health Office: Design/Implement Nursing Care Plan
- Health Office: Sports/Physical Education Clearance
- Asthma Care Program
- Educational Planning re: Home Instruction, Medical Transportation, Mobility Aide
- CPSE/CSE: Educational Planning
- Pupil Services: Provide student support
- Other: \_\_\_\_\_

I authorize the City School District of New Rochelle staff referenced above to release information about my child's health [mental health, please initial \_\_\_\_\_] condition to the provider/agency/hospital specified on the front of this form, including telephone dialogue and discussion.

Effective date of Authorization: \_\_\_\_\_ Signature date through June 30, 200 \_\_\_\_\_

I request a copy of this authorization.

Dated: \_\_\_\_\_  
MUST BE COMPLETED

\_\_\_\_\_  
AUTHORIZED SIGNATURE OR REPRESENTATIVE:

PLEASE PRINT Parent/Guardian _____
Address: _____ _____ _____
Home Phone: _____ Cell Phone: _____

\_\_\_\_\_  
RELATIONSHIP TO STUDENT

\_\_\_\_\_  
STUDENT (IF OVER 18 YEARS OF AGE)

I understand that I can revoke this authorization at any time by notifying the City School District of New Rochelle in writing, but if I do, the revocation will not have any effect on the actions the City School District of New Rochelle has already taken in reliance on this authorization.

INITIAL \_\_\_\_\_

DATED: \_\_\_\_\_