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GOUVERNEUR CENTRAL SCHOOL DISTRICT

Delivering the Promise of a Brighter Future

HEALTH OFFICE
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NURSING STAFF

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Middle School
(315) 287-4300

AUTHORIZATION FOR RELEASE OF RECORDS

Child's Name_____ DOB:_____

This authorization is written permission for GSCD to receive/disclose protected health information with my child's Health Care Provider as directed below:

I, _____, hereby authorize Community Health Center and/or_____
(Parent/guardian's name) *(Doctor's Name)*

to receive and disclose my child's protected health information with:

Gouverneur Central School District
133 East Barney Street
Gouverneur, NY 13642

Health records received/disclosed may include those related to the following:

- Shot Records
- Physical Exams
- Medications
- Visit Summary
- Health Care Concerns
- Behavioral Health
- Other_____

The protected health information will be disclosed for the following purposes:

School Requirements and/or other Requirements for students to participate in school related activities and programs.

I understand that this consent is effective until 90 days after I unenroll my child at GCSD.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notice to GCSD.

I understand that the revocation is only effective after it is received and recorded by GCSD and is not effective to the extent that GCSD/ my child's doctor has already relied upon the authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by GCSD and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be disclosed as permitted by federal law (or state law to the extent the state law provides greater access rights)

_____ _____
Signature of Parent or Legal Guardian Date