Woodward
Reaching. Teaching. Nurturing. Since 1957

201 West Merrick Road, Freeport, NY 11520
Tel: (516) 379-0900- Fax: (516) 379-0997
www.woodwardchildren.org

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION PUSUANT TO HIPPA

ENGLISH FORM

Student Name:_____ Date of Birth:_____

Healthcare Provider #1:_____

Address:_____

Telephone:_____ Fax:_____

Healthcare Provider #2:_____

Address:_____

Telephone:_____ Fax:_____

Healthcare Provider #3:_____

Address:_____

Telephone:_____ Fax:_____

I hereby authorize my child's physician(s) listed above to exchange the following information with Woodward Children's Center staff, including:

- ☐ Immunization/physical exams to comply with NYS regulations.
- ☐ Psychological evaluations/reports/social history.
- ☐ Medical clearance as needed following and injury or change in condition.
- ☐ Medical orders required for therapy needs; evaluations.
- ☐ Authorization for medications during the school day or on school trips.
- ☐ Medical condition/treatment plans that may have an impact in the school environment.
- ☐ Mental Health information.
- ☐ Other:_____

This information will be used to provide a safe and healthful environment and develop and appropriate program for this student at school. Enrollment is not contingent upon containing this release, however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment.

This release expires on the last day of the enrollment of the above student in school and may be revoked at any time by sending the request to cancel this permission in writing to the address above. Such revocation will not affect any disclosure made prior to its receipt. Protected health information will not be disclosed without consent per FERPA/HIPPA regulations. A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made. This form complies with all HIPAA regulations.

- ☐ I waive my right to receive a copy of this notice.

_____ _____

(Signature of student over 18 or Parent/Guardian Date

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AUTORIZACIÓN DE USO O DIVULGACIÓN DE INFORMACIÓN DE SALUD POSIBLE A HIPPA

FORMULA EN ESPAÑOL

Nombre del Estudiante:_____ Fecha de Nacimiento:_____

Proveedor de cuidado de la salud # 1_____

Dirección:_____

Telephone:_____ Facsímil:_____

Proveedor de cuidado de la salud # 2_____

Dirección:_____

Teléfono:_____ Facsímil:_____

Proveedor de cuidado de la salud # 3_____

Dirección:_____

Teléfono:_____ Facsímil:_____

Por la presente autorizo a los médicos de mi hijo enumerados anteriormente para intercambiar la siguiente información con el personal de Woodward Childrens Center, incluyendo:

- ☐ Inmunizaciones / exámenes físicos para cumplir con las regulaciones del estado de Nueva York.
- ☐ Evaluaciones psicológicas / informes / historia social.
- ☐ Autorización médica según sea necesario después de una lesión ó cambio en la condición.
- ☐ Órdenes médicas requeridas para terapia y evaluaciones necesarias.
- ☐ Autorización de medicamentos durante el día escolar ó en viajes escolares.
- ☐ Condición médica / planes de tratamiento que pueden tener un impacto en el entorno escolar.
- ☐ Información de salud mental.
- ☐ Otro: _____

Esta información se utilizará para proporcionar un ambiente seguro y saludable y desarrollar un programa apropiado para este estudiante en la escuela. La ins no depende de que contenga esta versión; sin embargo, para planificar el programa más apropiado para este estudiante, la información puede ser requerida. Se requieren vacunas específicas según las regulaciones del estado de Nueva York para la inscripción
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- ☐ Yo renuncio a mi derecho a recibir una copia de este aviso

_____ _____

(Firma del estudiante mayor de 18 años ó padre / tutor) Fecha