HIPAA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICALPROVIDERS and SCHOOLS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ Date of Birth_____
Last First MI

I, the undersigned, do hereby authorize (name of agency and/or health care providers):
(1) _**Northern Berkshire Pediatrics**_____(2) __**Berkshire Medical Center** ___
to provide health information from the above-named child's medical record to and from:

BUXTON SCHOOL
291 South Street
Williamstown, MA 01267

Buxton School Nurse and Faculty 413 458-3919
Contact Person Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following: ☐ All minimum necessary health information; or
☐ Disease-specific information as described:

_____

DURATION:

This authorization shall become effective immediately and shall remain in effect until_____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor (Buxton School) from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

PRE-DISCLOSURE:

I understand that the Requestor (Buxton School) will protect this information. The information will be shared with individuals working at Buxton School for the sole purpose of providing appropriate health services.

I have a right to receive a copy of this Authorization. Signing this Authorization is required in order for this student to obtain appropriate health services.

APPROVAL:

_____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone Number