Since 1961

ST. ELIZABETH SCHOOL

Helping Students with Special Needs Go the Distance

REQUEST and RELEASE of PROTECTED HEALTH and/or EDUCATIONAL INFORMATION (PHI)

(Valid through the duration of the 2023-2024 school year)

Student Name: _____ **Date of Birth:** _____

First Middle Last

Name of Parent/Guardian: _____ **Relationship to Student:** _____

Protected health and/or educational information ("PHI") includes:

- o Assistive Technology Assessments & Reports
- o Audiology Assessments and Reports
- o Discharge summaries
- o Medical Records (Including Immunizations)
- o Neuropsychological Reports
- o Official Transcripts
- o OT Assessments & Reports
- o Psychiatric Reports
- o Psychological Assessments & Reports
- o Psychosocial Summaries
- o PT Assessments & Reports
- o School Records
- o Speech & Language Assessments & Reports
- o Suspensions Logs

I authorize St. Elizabeth School to:

☐ **Obtain PHI** to assist in planning an appropriate educational program. During the school year, St. Elizabeth School may need to contact outside agencies to obtain documents or collaborate on your student's programming. Most commonly, these agencies include DDA, DORS, Autism Waiver Service providers, treating Psychologist, outside therapists (SLP, OT, PT, counselor), physician, and the Local School System.
☐ **Release PHI** to outside agencies to collaborate and provide continuity of care. During the school year, outside agencies may request information from St. Elizabeth School. Most commonly, these agencies include DDA, DORS, Autism Waiver Service providers, treating Psychologist, outside therapists (SLP, OT, PT, counselor), physician, and the Local School System.
☐ **Communicate with appropriate personnel** about the student's educational programming and delivery of therapeutic services within and outside the school setting. Communication may be verbal or electronic. Most commonly, these agencies include DDA, DORS, Autism Waiver Service providers, treating Psychologist, outside therapists (SLP, OT, PT, counselor), physician, and the Local School System.

I authorize the disclosure of PHI records to individuals affiliated with the school. I understand that, if the persons or organizations I authorize to receive PHI records are not subject to the federal or state health information privacy laws, they may further disclose the PHI records, in which case, it may no longer be protected by the health information privacy laws.

The authorization is valid for one school year. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school, may not be protected by HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA) and become part of the student's record.

_____ _____

Signature of Parent/Guardian (or eligible student) Date