



Health Office Authorization for Release of Information

This document is executed to ensure that the Larc School does not obtain, use or disclose legally protected health or medical information about your son/daughter without your permission or for the purposes other than those permitted by law.

We request your permission to obtain, use and disclose the following type of information about your son/daughter for the limited purposes identified herein:

- Medical diagnosis that affects educational programming and therapies such as Speech, Occupational Therapy, Physical Therapy
- Medical information needed to provide routine medical treatment during school hours
- Information needed to provide appropriate school health services
- Medical information that provides a staff member with a legitimate health interest to better understand your son 's/daughter's health needs:
 1. Including Cooper Hospitals' Physicians participating in the Larc School Outreach Program
 2. Students from local colleges participating in a Special Education Program
- Updated medical information as requested by your Child Study Team-Case Manager
- Any information/records requested by your Child Study Team or any other Program you may designate
- Informational forms:
 1. Social Security
 2. Division of Developmental Disability

Persons Authorized to Make Disclosures: Only the following persons are authorized to make the requested uses and disclosures of the information identified herein for the purposes identified herein:

- Larc School Registered Nurse(s).

Expiration Date / Revocation: This agreement shall expire automatically on June 30th at the end of the fiscal year. However you retain the right to revoke this authorization before that date in writing addressed to the Executive Director of the Larc School.

Consequences of Refusal to Sign: Your refusal to sign this document may not be used as the basis for denying your son 's/daughter 's treatment or educational programming.

Reuse / Re-disclosure of Information: Information disclosed under this authorization is subject to re-disclosure by the recipient; however, any information disclosed to any of the above will continue to be protected and will not be used or re-disclosed other than as authorized by you or permitted by law.

(Student's Name)

(Parent's Signature)

(Date)