Ballston Spa
Educating Everyone Takes Everyone
CENTRAL SCHOOL DISTRICT

Office of Special Education
Kerri A. Canzone-Ball, Ed.D.
Director of Special Education

(518) 884-7195, Ext. 1336
Fax: (518) 490-7410
E-mail: kcanzone@bscsd.org

HIPPA COMPLIANT RELEASE
AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION FROM MEDICAL PROVIDER TO THE BALLSTON SPA CENTRAL SCHOOL DISTRICT

TO: _____
Name of Doctor/Hospital/Provider

I, _____, parent/legal guardian of _____
Parent/Legal Guardian's Name **Student's Name**

authorize _____ to release the following records pertaining to your
Name of Physician/Agency

treatment of _____'s medical condition(s) including:
Student's First Name

- ***REQUESTED INFORMATION: laboratory tests, hospital/provider reports, evaluations, medical summaries, treatment notes, diagnostic evaluations, diagnostic impressions, admission and discharge documentation, psychiatric evaluations, office notes, correspondence, and medical information which will identify the nature of the student's diagnosis, prognosis and needs related to their physical or mental health.***

to the **Ballston Spa Central School District's CSE Chair/504 Chair/Other Person**, at:

_____
Name of School District Representative

Office of Special Education
70 Malta Avenue
Ballston Spa, NY 12020
518-884-7195, Ext. 1336
Fax: 518-490-7410

And I further authorize _____ to confer with the professional designated
Physician/Agency Representative

Ballston Spa

Educating Everyone Takes Everyone

C E N T R A L S C H O O L D I S T R I C T

Office of Special Education
Kerri A. Canzone-Ball, Ed.D.
Director of Special Education

(518) 884-7195, Ext. 1336
Fax: (518) 490-7410
E-mail: kcanzone@bscsd.org

by the District, _____ regarding _____
Staff Member Name/ CSE or 504 Chairperson **your/your agency's**

course of treatment and professional involvement with the above named student.

This authorization for communication includes discussion between _____ and
Physician/Agency

the District's _____ regarding records provided or to
Designated Staff Member/Title

provide clarification of the student's diagnosis, prognosis and treatment for purposes of educational planning, and, as necessary, authorize participation in educational planning meetings. This release is granted for the sole purpose(s) of assessing my child's academic, social/emotional and physical needs related to his/her medical condition as it relates to developing and implementing _____ designed to provide
a 504 Accommodation Plan/an IEP/a Transition Plan

my _____ with access to an appropriate education program and the ability to
Son/Daughter

access the District's supports, programs and services, including special education, as appropriate. Unless rescinded in writing, this authorization shall remain in effect for 12 months from the date signed.

I understand that I have the right to revoke this authorization, by sending written notification to the District's _____ and to you. I also recognize that any information is disclosed
CSE Chair/504 Chair/Designated Staff Member

prior to my revocation will be considered properly disclosed.

Date: _____

Name: _____

Address: _____

_____

Date of Birth: _____