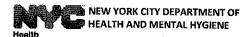


REQUEST FOR MEDICAL ACCOMMODATIONS TO BE COMPLETED BY STUDENT'S PHYSICIAN

	Physician Instructions: Please complete this form and return it to your patient's parent or fax to patient's school at If you have questions, please contact			
	(Student's Name) What limitations does this diagno	under my care for	(Diagnosis)	
		ention)		
	How does this limitation affect the (e.g. increases risk for fractures)	ne student's ability to ta		
	Expected duration of the limitation of the limit	on dations to accommod ol transportation (plea	se attach additional sheets a	
		odations to be provided	for: weeks	
	Provider's Original Signature			
	Print Name / Degree Date PARENT CONSENT FOR RELEASE OF MEDICAL INFORMATION			
	Please complete the attached Authorization for Release of Health Information Pursuant to HIPAA . This form is necessary in the event additional information is required from your physician to approve the request for medical accommodations. FOR SCHOOL USE ONLY			
z	Student's Name	DOB	ID#	
ACE YSICIAN AMP RE	Address			

E S E S E



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION DURSHANT TO HIDAA

Patient Name	Date of Birth	Patient Identification Number			
Patient Address					
*					
1, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability of 1996 (HIPAA), I understand that: 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV/AIDS* RELATED INFORMATION only if I place my initials on the appropriate line in Item 7. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 7. I specifically authorize release of such information to the New York City Department of Health and Mental Hygiene ("DOHMH"). 2. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, DOHMH is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of the people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights. 3. I have the right to revoke this authorization at any time by writing to the health care providers listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization might be redisclosed by DOHMH (except as noted above in Item 2), and this redisclosure may					
7. Specific information to be released and discussed: Entire Medical Record (written and oral) including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records send to you by other health care providers. If this box is checked, release and discuss only my Medical Record from (insert date) to (insert date)					
,,					
Other:	Includ	le: (Indicate by Initialing) Alcohol/Drug Treatment Information Mental Health Information HIV/AIDS-Related Information			
8. REASON FOR RELEASE OF INFORMATION: THIS INFORMAT	TION IS 9. THIS AUTHORIZA	TION WILL EXPIRE ONE (1) YEAR FROM THE DATE THIS			
RELEASED AT REQUEST OF THE PATIENT OR REPRESENTATIVE UNLESS OTHERWISE SPECIFIED HERE:	E AUTHORIZATION IS	AUTHORIZATION IS SIGNED BY THE PATIENT OR REPRESENTATIVE UNLESS OTHERWISE SPECIFIED HERE:			
10. If not the patient, name of person signing form:	ON BEHALF OF THE	11. THE PERSON SIGNING THIS FORM IS AUTHORIZED BY LAW TO SIGN (ON BEHALF OF THE PATIENT AS THE PARENT OR LEGAL GUARDIAN OF THE PATIENT, OR AS SPECIFIED HERE:			
All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.					
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZ	ZED BY LAW	DATE			
*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify					

someone as having HIV symptoms or infection and information regarding a person's contacts.