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 _____.

_____ is under my care for _____.
(Student's Name) **(Diagnosis)**

What limitations does this diagnosis cause? (e.g. severely limits ambulation)

_____

_____

_____

How does this limitation affect the student's ability to attend and participate in class? (e.g. requires constant medical attention)

_____

_____

_____

How does this limitation affect the student's ability to take transportation? (e.g. increases risk for fractures)

_____

_____

_____

Expected duration of the limitation _____

Please provide any recommendations to accommodate the student's needs in the classroom and/or during school transportation (please attach additional sheets as needed):

_____

_____

_____

I request transportation accommodations to be provided for: _____ weeks

I can be reached at: Tel#_____ **and/or Beeper** _____**on:**
Mon_____ **(hrs) Tue**_____ **(hrs) Wed**_____ **(hrs) Thu**_____ **(hrs) Fri**_____ **(hrs)**

Provider's Original Signature_____ License #_____

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

Student's Name _____DOB_____ID #_____

Address_____

PLEASE PLACE PHYSICIAN STAMP HERE

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, 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 of this disclosure.
5. Information disclosed under this authorization might be redisclosed by DOHMH (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMATION WITH, NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE.**

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: _____

_____

Include: (*Indicate by Initialing*)

_____Alcohol/Drug Treatment Information

_____Mental Health Information

_____HIV/AIDS-Related Information

8. **REASON FOR RELEASE OF INFORMATION: THIS INFORMATION IS RELEASED AT REQUEST OF THE PATIENT OR REPRESENTATIVE UNLESS OTHERWISE SPECIFIED HERE:**	9. **THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS SIGNED BY THE PATIENT OR REPRESENTATIVE UNLESS OTHERWISE SPECIFIED HERE:**
10. If not the patient, name of person signing form:	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 AUTHORIZED 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.**