MEDICAL EVALUATION REQUEST

PLEASE PRINT CLEARLY IN DARK INK – ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED

STUDENT ID OR DATE OF BIRTH	**STUDENT FIRST NAME**	**STUDENT LAST NAME**

HOW LONG HAS THIS STUDENT BEEN UNDER YOUR CARE?

WHEN DID TREATMENT BEGIN FOR THE CONDITION THAT IS THE BASIS FOR THIS REQUEST?

LIST THE DIAGNOSIS OR SYMPTOMATIC INDICATORS

HOW DOES THE LIMITATION AFFECT THE STUDENT'S ABILITY TO TAKE PUBLIC TRANSPORTATION?

THIS CONDITION IS ☐ **CHRONIC** ☐ **TEMPORARY**
IF TEMPORARY, WHAT IS THE ESTIMATED DURATION? _____

HAS THERE BEEN ANY RECENT CHANGE IN THE STUDENT'S CONDITION? ☐ **NO** ☐ **YES**
If yes, please describe:

PRESENT TREATMENT TO ACCOMMODATE STUDENT'S NEEDS DURING TRANSPORTATION:

REQUESTED ACCOMMODATIONS TO ADDRESS STUDENT'S NEEDS DURING TRANSPORTATION:

☐ Stop-to-School ☐ Curb-to-School ☐ Limited Travel Time ☐ Route with Fewer Children
☐ Nurse ☐ Mini-Wagon ☐ Climate Control (A/C) ☐ Oxygen Tank Required
☐ 1:1 Paraprofessional ☐ Other: _____

PHYSICIAN'S NAME (Please print - Required)	**LICENSE # (Required)**
ADDRESS	**TELEPHONE # (Required)**
PHYSICIAN'S SIGNATURE (Required)	**DATE (Required)**

I CAN BE REACHED ON:
MON _____ ***(HRS) TUE*** _____ ***(HRS) WED***_____ ***(HRS)***

THUR _____ ***(HRS) FRI*** _____ ***(HRS)***

PLEASE SUBMIT PROMPTLY. THIS EVALUATION EXPIRES 90 DAYS AFTER PHYSICIAN'S SIGNATURE.

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 Act 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") and the New York City Department of Education ("DOE"), which jointly operate the Office of School Health.
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 I have authorized to release my information. 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 may be redisclosed by DOHMH or DOE (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, THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE NEW YORK CITY DEPARTMENT OF EDUCATION**.

7. Specific information to be released and discussed:

All health information (written and oral) including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to my health care providers by other health care providers.

☐ If this box is checked, release and discuss only health information specified here:_____

(***Use this box if you do not want the entire record released or disclosed. Use box 9 below to set how long you want this form to last***)

Include: (*Indicate by Initialing*)

_____Alcohol/Drug Treatment Information. ***Specify records to be released and releasing organization:*** **_____**

_____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 EXPIRES ON THE DATE THAT PATIENT IS NO LONGER ENROLLED IN A SCHOOL OR PROGRAM OPERATED BY DOE OR SERVICED BY THE OFFICE OF SCHOOL HEALTH, UNLESS OTHERWISE SPECIFIED HERE**:**
10. **IF NOT THE PATIENT, NAME OF PERSON SIGNING FORM: (PARENT/GUARDIAN MUST COMPLETE)**	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.**

****If an expiration date is specified in item 9 above, the form will expire on that date and a new form must be submitted by the parent or legal guardian of the patient, or other persons authorized by law**.