National Jewish Health®

Morgridge Academy

Morgridge Academy Authorization to Use and Disclose Protected Health Information 2013-2014

303-398-1103

Child's Name: _____ DOB: _____

I, _____ , hereby authorize the healthcare providers below to release Records and/or speak with the staff at Morgridge Academy with regard to my child's medical care. Student records will be used to determine student eligibility for enrollment, class placement, academic, medical, and social/emotional goals, and program planning. The National Jewish/Morgridge staff that will have access to this information may include teachers, nurses, principal, therapists, clinicians, and physicians.

Regarding: ☐ Primary Care Physician (PCP) ☐ Medical Summary, PFT, Skin Testing ☐ Other: _____	Regarding: ☐ Psychiatrist ☐ Therapist ☐ Psychologist ☐ Counselor ☐ Social Worker ☐ Other: _____
Physician Name	Physician Name
Address, City, Zip Code	Address, City, Zip Code
Telephone Number Date Initials	Telephone Number Date Initials
Regarding: ☐ Specialist ☐ Medical Summary, PFT, Skin Testing ☐ Other: _____	Regarding: ☐ Specialist ☐ Medical Summary, PFT, Skin Testing ☐ Other: _____
Physician Name	Physician Name
Address, City, Zip Code	Address, City, Zip Code
Telephone Number Date Initials	Telephone Number Date Initials

_____ _____ _____

Parent/Guardian Signature Witness Signature Date

National Jewish Health may not condition treatment, placement, or eligibility for benefits on whether you sign this authorization; however, if you do not authorize the release of this information, you will be denied enrollment in the school. This authorization may be cancelled at any time by means of a written request. If you do cancel this authorization, Morgridge Academy staff will still have access to the protected health information disclosed before the date of the cancellation. After your protected health information has been disclosed, other individuals or entities may re-disclose it. This authorization will not exceed a four-year period of time.