School Nurse Liaison Referral

(Please complete as much of the top half of this form as possible.)

Children's® Healthcare of Atlanta

Parental Permission needs to be signed on attached form (see highlighted areas)

Date of referral:______________________________

Child's full name:_____________________________
DOB:_______________________________________

Child's diagnosis:______________________________
Is this a new diagnosis? Yes____No_____
Name of school:_________________________________
Grade:____
County/School district:___________________________
Contact person at school:_________________________
Anticipated return to school date:__________________

Referral from:
Name:__________________________________
Title:__________________________________
Location:_______________________________
Phone #:________________________________

Specialty physician:_________________________
Office phone #:_____________________________
Fax #:___________________________________

Parent Name:______________________________
Best Contact Phone #:_______________________

Healthcare needs at school / Type of health services, limitations or information requested:

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Fax referral to School Nurse Liaisons as listed below:

Maryann Morris: phone 404-785-7240 fax 404-785-9707 (**Asthma only**)
Theresa Kuhn: phone 404-785-7239 fax 678-465-9154 (Clayton, Coweta, Fayette, Henry, Newton, Rockdale, Spalding)
Angela Bryant-Curry: phone 404-785-7238 fax 678-715-8546 (Atlanta City, Carroll, Cobb, Decatur City, Dekalb, Douglas, Marietta City, Paulding and counties not in listed metro area)
Monica Collins : phone 404-785-7220 fax 770-638-3531 (Bartow, Cartersville City, Cherokee, Dawson, Fulton, Forsyth, Pickens)
Maryann Montigel: phone 404-785-7219 fax 770-518-6617 (Barrow, Buford City, Gainesville City, Gwinnett, Hall, Walton)

Outcome: (For Nurse Liaison's Use):

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CHILDREN'S HEALTHCARE OF ATLANTA
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

______________________________ **(PRINT PATIENT'S Full Name)**

______________________________ **(PATIENT'S Date of Birth)**

______________________________ **(PRINT name of Parent/Legal Guardian, or Patient (if 18 years of age or older)**

______________________________ **(DAY Phone Number & Area Code)**

Check (v) one. I am the ☐ **Patient (must be 18 years of age or older)** ☐ **Parent or** ☐ **Legal Guardian with custody (please state relationship to the patient)** ______________________________

☐ **Call to pick up records:** **OR** ☐ **Mail records to:**

______________________________ **(DAY Phone Number & Area Code)**

______________________________ **PRINT Name of Individual(s) or Agency**

______________________________ **PRINT (Street Address or Box Number)**

______________________________ **PRINT (City, State and Zip Code)**

- **I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders.**
- **I authorize the inspection of the above information by the above named agency/person and/or to the furnishing of a photostat or other copies.**
- **I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information disclosed prior to Children's Healthcare of Atlanta receiving a written notice of withdrawal.**
- **I hereby release Children's Healthcare of Atlanta and its officers, directors, agents, and employees from any and all liabilities, responsibilities, damages, losses, and claims which might arise from the release of the information authorized above.**
- **In furtherance of this authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.**
- **I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily authorize the disclosure of this medical information to the individual or agency named above.**

Check (✔) treatment location(s) from which you would like records released:
☐ **Children's at Scottish Rite**
☐ **Children's at Egleston**
☐ **Satellite Facility (list locations):** ______________________________
☑ **All of these locations**

Check (✔) location(s) you are permitting to process your request:
☑ **HIS/Medical Record Department**
☐ **Satellite Facility**
☐ **Other Department:** ______________________________

THE FOLLOWING INFORMATION IS TO BE RELEASED Check (v) Correct Document(s)

☐ Autopsy Report	☐ Face Sheet	☐ Nurses Notes	☐ Radiology Reports
☐ Clinic Notes	☐ History & Physical Exam Report	☐ Operative Reports	☐ Rehabilitation Records
☐ Consultations	☐ Immunization Records	☐ Pathology Reports	☐ Therapy Notes
☐ Discharge Summary	☐ Laboratory Reports	☐ Photographs	☑ **ALL OF THE ABOVE**
☐ Doctor's Orders	☐ Medication Records	☐ Progress Notes	☐ Others (Specify)
☐ Emergency Room Record	☐ Neuropsychological Reports	☐ Psychosocial Notes	______________

Applicable Dates/Encounters (Specify) ______________________________
The purpose for which this release is being requested is: ☑ Continuing Medical Care ☐ Legal Action/Review
☐ Insurance Reimbursement ☐ Others (Specify) ______________________________
☐ Undeclared (at the request of the below signed)
Any disclosure of medical information by the recipient(s) is prohibited except when implicit in the purpose of this authorization.
This authorization expires ______________ (insert applicable date or event or insert "no expiration designated") or in 6 months (**12 months for school requests**), whichever is shorter, and no further use/disclosures as described above may be made after the expiration. Authorizations apply only for medical records for specified treatment dates prior to and on the date of signature, unless otherwise specified. **Specified exceptions for future-dated releases are**: ☑ School ☐ Other ______________________________

Signature: ______________________________ **Date:** ______________

INTERNAL USE ONLY

☐ Faxed ☐ Mailed ☐ Pick-up/Called: ______________ Date: ______________ Initials: ______________