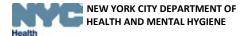
## REQUEST FOR SECTION 504 ACCOMMODATIONS 2020-2021

Name of StudentSchool Name		D <sub>1</sub>	DOB Student II		
		School ATS/DBN: Grade/Cla		ss	
Name of Requesting P	arent/Guardian				
Date Submitted to the			Name of 504 Coordinat		
Does the student have	a current IEP2	□ Yes □ No	504 Coordinator Tel		
	•	e and submit to the schoots the student's performance	ool's 504 Coordinator		
Request accommodation	Reques	t for Accommodation(s)	ontact your school's 504 Coordina		estions. I use only Renewal
Testing		Check all requested:	10 ( )	-	
Accommodations		e/administration time (e.g. extende	d time, etc.)		
Accommodations	☐ Test setting/lo		hpology.		
		esentation/Directions/Assistive Tec	chnology		
		t response/content support			
Classroom /	☐ Other (please ☐ Class schedu				
Curriculum					
Accommodations	☐ Class activitie	•	phology		
Addominoudiono	-	sentation/Directions/Assistive Tec ss activities response/Content Sup			
	Other (please	·	эрогс		
Academic Supports	☐ Paraprofession				
and Other Services	· ·				
	□ Nursing Servi		Down of Form		
	·	n (complete OPT Medical Exception	on Request Form)		
	,	igh school only)			
		s unable to self-administer, medication	n is generally administered by the school nurse. In Office of School Health Practitioner in order to	Requests for 1:1 nui	sing, paraprofess
ditional forms must be completed; Int 2: PARENT CONSE ur child may qualify for accords, classwork, classroom	please check with your 504  NT - Parent/Guar  ommodations under so  observations, testing	Coordinator.  rdian must complete bef Section 504 of The Rehabilitat , and health care practitioner's	fore submitting to your school ion Act of 1973. Your school's 504 to statement. If your child qualifies for lewed at any time of the year, but 504	l's 504 Coord eam will meet to services based	linator review your on that revie
signing this form: 1) You an You confirm that you have p Department of Education ( d DOE may obtain any oth	rovided full and comp DOE) are relying on t ner information they	lete information to the best of y he accuracy of the information	d's records and decide if your child que rour ability. 3) You understand that the non the form for their review and decivild's medical condition, medication on child health services.	Office of Schoo sions. 4) You ur	Health (OSH)
Completed HIPAA form	attached (REQUIR	ED FOR REVIEW. PARENTS	S MUST COMPLETE THE BACK O	F THIS FORM).	
me of Parent/Guardian			_ Daytime Phone Number		
gnature of Parent/Gua	rdian		Date		



## **AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

Dationt Address	Patient Identification Number	Date of Birth	Patient Name
ratient Address			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.

CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE NEW YORK CITY DEPARTMENT OF EDUCATION.						
•	istories, office notes (except psychotherapy notes), test results, nsurance records, and records sent to my health care providers by					
☐ If this box is checked, release and discuss only health inform (Use this box if you do not want the entire record released or d	nation specified here:					
Include: (Indicate by Initialing) Alcohol/Drug Treatment Information. Specify records to Mental Health Information HIV/AIDS-Related Information	be released and releasing organization:					
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:	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.					

\*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.

DATE

OSH-13 HIPAA Rev.04.2019 FOR PRINT USE ONLY

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

<sup>\*\*</sup>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.