

HIPAA Compliance

South Kent School is compliant with "HIPAA" rules and regulations. Medical information is held in strictest confidence with our medical staff.

However, there may be occasions when our medical staff needs to notify faculty members that a student will miss a school obligation because he/she is ill, has a medical issue or concern, or has an appointment with a specialist. Faculty may also be notified when a student's medical condition is serious enough that a medical leave of absence is necessary. Medical information is never disclosed, only the fact that there is an absence for a medical reason. In addition, our medical staff may also need to call an outside consultant to make a referral for a specialist on a student's behalf.

Thus, under the privacy regulations, we must have consent from parents to disclose the fact of student absences and necessary communication with off-campus health care providers.

Parents must sign the form on the next page for their son/daughter to enroll at South Kent School.

Use and Disclosure Covered by this Authorization

This form authorizes South Kent School's student health services staff, and affiliated health care providers under contract with the School which provide health care to students ("affiliated health care providers"), to use the student's health information, and disclose the student's health information to each other, for the following purposes: (1) to evaluate whether a medical leave of absence is appropriate as described in the Student Handbook or (2) to evaluate whether to make an administrative request to initiate a non-disciplinary response to the student's use of alcohol or drugs as described in the Handbook or (3) to evaluate whether accommodations at the School are recommended or necessary to address the student's health-related condition (such as, for example, permission to miss a class while the student is receiving follow-up care from a physical therapist for a knee injury). This form also authorizes the student health services staff and affiliated health care providers to share the student's health information with School administration, faculty, dorm parents, and the Headmaster of the School to the extent necessary to make their recommendation about the items described above. The student's health information that may be used or disclosed as described above includes information acquired by the student health services staff, and affiliated health care providers, when they provide health care to the student on-campus. It also includes health information that is acquired by affiliated health care providers when they provide health care to the student off-campus at their private practice offices or at a local hospital.

Specific Understandings

To the extent that the student's health information described above is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), it is called "protected health information." HIPAA requires that you be informed of the following before you sign this authorization form for the use and disclosure of protected health information.

By signing this authorization form, you authorize the use or disclosure of the Student's protected health information as described above. This information may be redisclosed if the recipients described on this form are not required by law to protect the privacy of the information, and such information is no longer protected by the HIPAA privacy regulations.

You have a right to refuse to sign this authorization. The student's health care, payment for health care, and health care benefits will not be affected if you do not sign this form. However, the student's enrollment at the School is contingent upon this form being signed and remaining in effect.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the student health services staff, or affiliated health care providers, have already taken action based upon your authorization. However, the student's enrollment at the School is contingent upon this form being signed and remaining in effect. To revoke this authorization, please write to Fleur Vining in the Health Center. You have a right to receive a copy of this form after you have signed it.