BABOQUIVARI UNIFIED SCHOOL DISTRICT

P.O. Box 248
Sells, Arizona 85634
(520) 719-1200
Fax: (520) 383-5441
www.busd40.org

SCHOOL HEALTH

Tricia Logan, RN
BUSD District Nurse
Barbara Nunez
Health Aide-Primary Campus
Rhonda Enriquez
Health Aide-Intermediate Campus
Tonweya Narcho
Health Aide-Secondary Campus

SUPERINTENDENT
RUBEN DIAZ

VISION:
Our students will be loved, encouraged, and prepared to take on the world by embracing our Himdag.

MISSION:
We create Healthy Inspiring, Motivating Developing Achieving Graduates.

OUR PURPOSE
We create a positive academic impact on every child's life, everyday; with and additional commitment to support the Tohono O'odham culture and language

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, ____, hereby voluntarily
(Name of Parent/Guardian)
authorize the disclosure of information from my minor child's health record:
Name of Student:__________________________ Date of Birth:______________________

II. The information is to be disclosed to: Baboquivari Unified School District-School Health at PO Box 248, Sells, AZ 85634

III. The purpose or need for this disclosure: Care coordination between BUSD Health Office staff and ____________________________________.
(Name of Facility/Organization)

IV. The information to be disclosed from minor child's health record: Only information needed to coordinate care between medical facility and BUSD School Health:

_____ Clinic/ED visits _____ Pharmacy _____ Physical Therapy
_____ Social Services _____ Dental services

Date of Service: ________________________to__________________________

V. Permission to speak directly with individuals providing any of the care checked above: YES NO

VI This authorization for use or disclosure of protected health information is for the school year: _____________

____ ________________________
(Signature of Parent/Guardian) (Date)

I understand that I may revoke this authorization, in writing, at any time to the Health Information Management Department, except for information released prior to the date of the revocation of this authorization.

____
(Signature of Parent/Guardian)