

SWCCCASE ANNUAL MEDICAL UPDATE FOR OT/PT

(Physician's Name)

Our Occupational/Physical Therapy Department obtains a physician's consent upon initiating direct services. The procedure recommended by the Illinois Medical Association is for an **annual medical update** to be submitted. Our request for information updates is to ensure that we are able to provide treatment which is consistent with each student's current medical status.

If you would like to discuss the Occupational/Physical Therapy services provided, the therapist can be contacted at (708) 687-4770, voicemail # _____. Please leave a time and phone number for us to return your call. Thank you.

Student's Name: _____ Birthdate: _____ Date of Initial Consent: _____

Parent: _____ Address: _____

District of Residence: _____ Present OT/PT Services: _____

Current Emphasis of Therapy: _____

Physical Therapist

Occupational Therapist

Parent Authorization:

I authorize the release and exchange of health, medical and educational information and records between Southwest Cooperative and _____ (Physician(s) or Agency(ies) related to the provision of the occupational and/or physical therapy services described above. This authorization is valid for one calendar year and will expire on _____. I understand that I may revoke this authorization in writing at any time. I understand that my revocation of this authorization will not be effective for actions taken in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of the foregoing information and records may adversely impact the educational programming and/or medical treatment provided to my child. I understand that health or medical records, once received by SWCCCASE, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the *Family Educational Rights and Privacy Act*. I understand that health, medical or education records once received by an authorized third party that is not a covered entity or related to SWCCCASE, may not be protected by the HIPAA Privacy Rule or the *Family Educational Rights and Privacy Act*. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain emergency health care. I also understand that I have the right to a copy of this document, the right to see and copy all health, medical and educational information used or disclosed, and the right to inspect and copy health, medical and educational records and to challenge their contents.

Parent Signature (do not sign until completed): _____ Date: _____

Student Signature**: _____ Date: _____

Witness Signature: _____ Date: _____

**Student signature required if the minor student is over age 12, has the capacity to sign, and this authorization is for the release or mental health records.

Physician's Update:

Medical Instructions or Precautions relating to Treatment provided by Occupational/Physical Therapy:

Current Medication and/or potential side effects: _____

Other medical services provided: _____

Physician's Signature

Date

Name and Address of Physician: _____

Phone

Please return this form with any pertinent medical information to the OT/PT Department at Southwest Cooperative, 6020 W. 151st Street, Oak Forest, IL 60452 or fax to (708) 687-5695.