REQUEST FOR SECTION 504 ACCOMMODATIONS 2016-2017

Name of Student _____ DOB ___/___/___ Student ID# _____

School Name _____ School ATS/DBN: _____ Grade/Class _____

Name of Requesting Parent/Guardian _____ Relationship to Student: _____

Date Submitted to the 504 Coordinator ___/___/___ Name of 504 Coordinator _____

PART 1: To be completed by the parent/guardian; submit to the school 504 Coordinator

Describe the concern below and how it affects the student's educational performance:

Indicate accommodations requested based on the concern above. Please consult the school-based 504 Coordinator with any questions.

Request for Educational Accommodation(s) *Check all requested:*		*For school use only* Approve	Deny
Testing Accommodations	☐ Test schedule/administration time (e.g. extended time, etc.)	☐	☐
	☐ Test setting/location	☐	☐
	☐ Method of presentation/Directions/Assistive Technology	☐	☐
	☐ Method of test response/content support	☐	☐
	☐ Other (please specify)	☐	☐
Classroom / Curriculum Accommodations	☐ Class schedule/use of time	☐	☐
	☐ Class activities setting	☐	☐
	☐ Method of presentation/Directions/Assistive Technology	☐	☐
	☐ Method of class activities response/Content Support	☐	☐
	☐ Other (please specify)	☐	☐
Academic Supports and Services	☐ Health Paraprofessional* ☐ new request ☐ renewal request	☐	☐
	☐ Safety Net *(high school only)*	☐	☐
	☐ Other (please specify) _____	☐	☐
Other Accommodation (please specify)**		☐	☐
		☐	☐
		☐	☐

* Paraprofessional requests must be reviewed by an Office of School Health Physician in order to determine medical necessity. Additional forms must be completed; please check with your 504 Coordinator.

**Transportation Requests: A Medical Evaluation Request form, available on the DOE website, must be used for specialized transportation accommodations.

Part 2: PARENT CONSENT - To be completed by the student's parent/guardian prior to submitting to School 504 Coordinator

To determine whether your child is eligible for accommodations under Section 504 of The Rehabilitation Act of 1973, a school-based 504 team will convene to review your child's records, including the physician's statement (if applicable), classroom observations and assignments, assessment data, and other information. If your child is eligible to receive accommodations, a 504 Plan will be developed with your input and consent. The 504 Plan may be reviewed at any time, but at a minimum must be reauthorized each school year..

By signing this form, you are giving consent to the 504 team to review your child's records and take the necessary steps to determine whether your child is eligible to receive accommodations. You also acknowledge that you have provided full and complete information to the best of your ability and understand that the Office of School Health (OSH), New York City Department of Education (DOE), their agents, and their employees are relying on the accuracy of the information provided to determine whether and to what extent your child may receive accommodations under Section 504. Additionally, you hereby authorize OSH and DOE and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to your child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to your child.

□ Completed HIPAA form attached (REQUIRED FOR REVIEW; PARENTS MUST COMPLETE THE BACK OF THIS FORM).

Name of Parent/Guardian _____ Daytime Phone Number _____

Signature of Parent/Guardian _____ Date _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
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 the 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* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). 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 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient 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 people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-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 provider listed below. 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 might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **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.**