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Date: ___________________

Dear Teacher:

The parents of one of your students are seeking to have their child evaluated by our office for a health concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of behavioral rating scales. This information is important for the diagnosis and treatment of your student.

Your time and cooperation in this matter is greatly appreciated. Attached please find a Release of Information Form that the parents have completed and a set of teacher rating including:

1. NICHQ Vanderbilt Teacher Assessment Scale

2____

Generally, the teacher who spends the most time with the child should complete the teacher rating scales. However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of rating scales from each teacher. If more than one set of rating scales is required, please call our office or have the parent contact us. We will forward additional rating scales as needed. Please note that <u>the same teacher</u> should complete each entire set of forms.

Please fill out the forms as completely as possible. If you did not know the answer to a question, please write, 'Don't know', so that we can be sure the item was not simply overlooked. Some of the questions in the rating scales may seem redundant. This is necessary to ensure that we obtain accurate diagnostic information

We ask that you complete these forms as soon as possible, as we are unable to begin a child's evaluation without the teacher rating scales. **The forms should be faxed to our office as soon as possible**.

Thank you for your assistance and cooperation in the completion of these forms. If you have any questions, please do not hesitate to contact us.

Sincerely,

Authorization for Release of Protected Health Information and Coordination of Care:

Students Name: __________________________________

School:

Name: ____

Organization:

Name: <u>Brighton Hill Pediatrics</u>

Reason for Release of Protected Health Information: Psychoeducational information/testing; mental health; medical diagnoses; coordination of care.

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the protected health information. I do not have to sign this authorization in order to receive treatment from Brighton Hill Pediatrics. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPPAA Privacy Rule. Brighton Hill Pediatrics, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer.

Request for minor: (under age 18) should be signed by the parent having legal custody or by the legal guardian; except in situations protecting the minor's privacy as stated by NY State Health Code regulations. As a minor in New York State you may seek treatment for certain conditions without knowledge or consent of his/her parents. In alcohol or drug abuse cases, reproductive health or mental health cases, only the minor may have access to the medical records unless he/she specifically gives consent for his/her parents or guardian to obtain information.

Authorization will expire 12 months from the date this form is signed, unless noted here: ______________________________

Date: ____/____/____ Patient Signature: ____ (age 13 yrs +)

Date: ____/____/____ Legal Representative: ______________________________________