

## VOLUNTARY AUTHORIZATION

**A PARENT/GUARDIAN/PARTICIPANT MAY CHOOSE TO COMPLETE THIS SECTION GIVING PERMISSION TO THE LICENSED PHYSICIAN TO DISCUSS AND CLARIFY A DIET ORDER WITH A DIRECTOR OF A SCHOOL, CENTER OR SITE.**

Note to Parent(s)/Guardian(s)/Participant: As stipulated in FNS Instruction 783, Rev. 2, Section V Cooperation: "When implementing the guidelines of this instruction, food service personnel should work closely with the parent(s)/guardian(s)/participant or responsible family member(s) and with all other medical and community personnel who are responsible for the health, well-being and education of a participant with a disability that affects the diet to ensure that reasonable accommodations are made to allow the individual's participation in the meal service.

This voluntary authorization encourages such cooperation by allowing the following:

- After review of this Special Diet Statement, the school, center or site may need more information or clarification from the physician before it can provide the special diet. By signing this authorization you are permitting the school, center or site to discuss or clarify the diet order with the physician.
- Before any changes agreed to between the director of the school, center or site and physician take place, the parent(s)/guardian(s)/participant need to be informed.
- The changes agreed to will then be incorporated into an amended Special Diet Statement.
- If more information is needed but this authorization statement has not been signed, implementation of the special diet may be delayed.
- If authorization is signed, make a copy of this document before submitting to the school, center or site.

This authorizes the licensed physician to discuss or clarify the diet order prescribed for \_\_\_\_\_  
(participant's name) with the director at \_\_\_\_\_ (name of school/center/site).

This authorization will remain in effect until the diagnosis has changed or a new diet order is prescribed.

This authorization may be revoked at any time by submitting a request in writing to the physician who originally signed the Special Diet Statement.

I understand that specific information disclosed pursuant to this authorization may be subject to re-disclosure by the school/center/site director and will no longer be protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
OR Participant's Signature (Adult Day Care)

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