LATHROP RII SCHOOL DISTRICT

HIPPA AUTHROTIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The undersigned hereby authorizes and requests that:

_____
Name of Health Care Entity or Professional

_____
Address: Street/City/State/Zip

_____
Phone/Fax

Release confidential health information regarding:

_____
Patient's name

___-____-_____
DOB

_____
Address

This authorization will expire on: ____/_____/_____ or one year after date signed if not specified.
The requested information is needed for: _____
The following person(s) may receive protected health information about my child:

_____
Nurse/Education Team School

_____
Address: Street/City/State/Zip Phone/Fax

Check the following items being requested:

_____Hospital Discharge Summary
_____List of Medications
_____Complete Medical Record
_____Partial Medical Record
Specify_____
_____Social History
_____Brief Outpatient Summary
_____Brief Therapy Notes
_____Other _____

Drug and/or alcohol abuse, and Psychiatric and/or HIV/AIDS release:
If the medical records contain information about mental health, genetic information or HIV/AIDS, I authorize its release: YES_____ NO_____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. Treatment, eligibility for services and education may not be conditioned on signing this authorization
3. I may revoke this authorization at any time in writing, but that wound not affect any actions taken prior to receiving the revocation.
4. If the requester/receiver is not a healthcare professional, the information may no longer be protected by federal privacy rules and may be re-disclosed
5. I understand that information related to drug and/or alcohol abuse will be released.
6. I understand I can obtain a copy of the information described in this form.
7. I will receive/have access to a copy of this form after I sign it upon request.

Signature of Student/Parent/Guardian: _____Date:_____
Printed Name of Student/Parent/Guardian:_____
Relationship to Student:_____
Witnessed by: _____