INDEPENDENCE SCHOOL DISTRICT
HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The undersigned hereby authorizes and requests that:

_____
Name of health care entity or professional

_____
Address

_____
Phone/Fax

Release confidential health information regarding:

_____
Patient's Name Date of Birth

_____
Address Phone Number

_____ ____-_____-_____
Social Security Number

This authorization will expire on: ____/_____/_____ or one year after date signed if not specified.

The purpose of this disclosure is to: release to_____, obtain from_____, or to exchange verbal information with:_____.
The requested information is needed for: _____.
The following person/s may receive protected health information about my child:

_____
Nurse/Education Team School

_____
(Address, phone and fax)

Check the following items being requested:

_____Hospital Discharge Summary
_____List of Medications
_____Complete Medical Record
_____Partial Medical Record – indicate
_____Other_____
items to be released:_____

_____Social History
_____Brief Outpatient Summary
_____Brief Therapy Notes

Drug and/or alcohol abuse, and/or psychiatric and/or HIV/AIDS release:
If the medical records contain information about drug and/or alcohol abuse, mental health, genetic information, 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 would not effect 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 redisclosed.
5. I understand I can obtain a copy of the information described in this form.
6. I will receive a copy of this form after I sign it.

Signature of Student/Parent/Guardian: _____ Date: _____
Print name of Student/Parent/Guardian: _____
Relationship to Student/client: _____
Witnessed by: _____ Date: _____