AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION TO SCHOOL DISTRICT

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____/_____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____

To disclose ANY AND ALL DOCUMENTS AND MEDICAL RECORDS PERTAINING TO THE EXAMINATION, CARE, DIAGNOSIS, AND TREATMENT OF THE PATIENT, INCLUDING PSYCHOLOGICAL AND PSYCHIATRIC AND/OR PSYCHOLOGICAL CONDITIONS, INCLUDING BUT NOT LIMITED TO ALL OFFICE, EMERGENCY ROOM, COUNSELING, INPATIENT AND OUTPATIENT CHARTS AND RECORDS, NURSE'S NOTES, PATIENT QUESTIONNAIRES, RADIOLOGICAL REPORTS, COLOR PHOTOGRAPHS, PHYSICAL THERAPY AND REHABILITATION RECORDS INCLUDING ALL DESCRIPTIONS OF EXERCISES PRESCRIBED; SIGN-IN SHEETS, AND DOCUMENTATION WHICH INDICATE DATE(S) AND TIME(S) OF PATIENT'S APPOINTMENTS; ALL FILMS, INCLUDING X-RAYS, MRI'S, CT SCANS, RAW DATA, IMAGING STUDIES AND DIAGNOSTIC STUDIES; MEDICAL BILLS, MEDICAL BILLING RECORDS, LIENS, EXPLANATION OF BENEFITS STATEMENTS, CORRESPONDENCE RELATING TO BILLING, RECORDS SHOWING WRITE-OFFS OF AMOUNTS BILLED, AND RECORDS OF PAYMENT BY INSURANCE CARRIERS, GOVERNMENTAL ENTITIES AND/OR ANY OTHER PERSON OR ENTITY, REGARDLESS OF DATE to:

_____ _____
School District to which disclosure is made Address/City & State/Zip Code

_____ _____
Contact person at School District Area code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following: ☐ All health information; or ☐ Disease-specific information as described: _____

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization:

I understand this authorization is voluntary. Treatment may not be conditioned on signing this authorization.

I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization. The information released in response to this Authorization may be re-disclosed to other parties.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

I understand the contents of this written authorization in its entirety and have asked questions about anything that was not clear to me, and am satisfied with the answers I have received.

Signature of Patient: _____

Signature of person acting on behalf of patient: _____

Relationship to Patient: _____
(If an appointed Guardian, please attach documentation)

Date: _____

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IF APPLICABLE, PLEASE COMPLETE THE FOLLOWING:

I consent to the release of any and all records related to the treatment of, or diagnosis for, Drug, Alcohol, Psychiatric or HIV/Aids related conditions under the same terms as outlined above. I understand that such information cannot be released without my specific consent.

Signature of Patient: _____

Signature of person acting on behalf of patient: _____

Relationship to Patient: _____
(If an appointed Guardian, please attach documentation)

Date: _____