**RELEASE OF INFORMATION**

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  *Name of Student Student Date of Birth Student Social Security Number*

|  |  |  |
| --- | --- | --- |
| 1. AUTHORIZES (Physician Name/Information Here): |  | 2 P. TO RELEASE ROTECTED HEALTH INFORMATION TO:HART COUNTY BOARD OF EDUCATION |
|  Street Address: |  |  Street Address:25 QUALITY STREET |
|  City, State, Zip Code: |  |  City, State, Zip CodeMUNFORDVILLE, KENTUCKY 42765 |

My protected health information will be used or disclosed upon request for the following purposes: *(Name and explain each purpose)*  educational placement decisions

This authorization for use and/or disclosure applies to the information described below *[mark those that apply]:*

[ ]  Any and all records including mental health, HIV, and/or substance abuse records. *[Cross out any item you do not authorize to be released]*

[ ]  Records regarding treatment for the following condition or injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

on or about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[ ]  Records covering the period of time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other *[please specify – include dates]* complete attached medical/physician questionnaire

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to HART COUNTY BOARD OF EDUCATION . I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that HART COUNTY PUBLIC SCHOOLS may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on *[please list a specific date or event]*  ONE YEAR FROM DATE OF CONSENT

I certify that I have received a copy of this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Patient or Personal Representative Date*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of Patient or Personal Representative*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Description of Personal Representative’s Authority*