TALLADEGA COUNTY SCHOOLS

HIPAA Authorization for Release of Information

Patient Information:
Patient Name (Last, First, MI):____

Address:____

Phone Number: (______)_________________________

This Authorization applies to the following Information:

□ **All** information. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HV information, and/or other sensitive health information and I expressly consent to the release of the information.

□ **Only** the following records or types of Information:_____________________________
____
____

Treatment Dates:
From (month/day/year) _____/_____/_____ **To** (month/day/year) _____/_____/_____

The information may be released as follows (Please provide address and phone number):

***From* Person/Organization providing the Information:**______________________________
Address and Phone Number:____

***To* Person/Organization receiving the information:**________________________________
Address and Phone Number:____

Purpose of Release:

□ Continuity of Treatment
□ Other (Please Specify):____

I understand the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available for the HIPPAArific practice. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient’s health care and the payment for the patient’s health care will not be affected if I do not sign this form. I understand I may see and copy the Information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the Information to be released as described above.

________________________________ ________________________________
Parent/Legal Guardian Printed Name Parent/Legal Guardian Signature Date

________________________________ ________________________________
Patient Signature if 14 or older Date Witness Signature for Patient/Parent/ Legal Guardian Date