Request for Protected Health Information

This form should be used when release of a patient's protected health information is being made to the health care provider for an employee or student for a purpose other than treatment, payment or health care operations.

I, _____, hereby authorize _____
Name of Employee, Student 18 or older, or Parent/Guardian *Name of Physician/Practice*

to use and/or disclose my protected health information described below to Bainville K-12 Schools.

My protected health information will be used or disclosed upon request for the following purposes (name and explain each purpose): _____

_____

This authorization for use and/or disclosure applies to the following information (please mark those that apply):

- ☐ Any and all records in the possession of the above-named physician or physician's practice, including mental health, HIV, and/or substance abuse records. (Please 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 (Specify and include dates.)_____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to above-named physician/practice. 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 the above-named physician/practice 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 re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on the following date or event: _____.

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

_____ _____
Signature of Patient or Personal Representative *Date*

_____ _____
Name of Patient or Personal Representative *Personal Representative's Authority*