PETERS TOWNSHIP SCHOOL DISTRICT

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
BY THE: Primary Care Physician

_____, am the parent or legal guardian of an unemancipated minor. I represent that I have the capacity to make this authorization for the use or disclosure of the protected health information of _____.

I. I hereby authorize_____attending/treating physicians to use and/or disclose the following protected health information: (describe information in detail below)

Specific diagnostic medical information:_____

Medical records:_____

Verbal communication with treating physician:_____

II. The person or persons authorized to use of disclose this protected health information is/are:

_____Principal/Administrator_____

_____School Nurse at _____

_____ Counselor at _____

III. The person or persons to whom the personnel identified in #2 above may disclose this protected health information is: (identify recipient of information)

_____

IV. The purpose of the use or disclosure of this protected health information is:

_____

V. This authorization is valid from _____ to _____.

Notice of Important Rights

You have the right to revoke this authorization at any time. In order to revoke this authorization, you must notify the School Principal in writing of your revocation. Your revocation will be effective immediately upon receipt by Peters Township School District of your written notification, except to the extent that the Peters Township School District has acted in reliance on your authorization.

The health insurance provider may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign the authorization, except that the health insurance group health plan may condition enrollment in the health plan or eligibility for benefits on the provision of an authorization requested by the health insurance group health plan prior to your enrollment in the health plan for the purpose of underwriting or risk rating determinations.

The protected health information used or disclosed in accordance with this authorization could be redisclosed by the recipient and no longer protected by the privacy policies of _____(attending/treating physicians) or the requirements of the Health Insurance Portability and Accountability Act of 1996.

My signature below acknowledges that I have read the Notice of Important Rights and that I agree to authorize the use or disclosure of protected health information, in accordance with the terms and conditions of this authorization.

_____ _____

Signature Date