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 ________________________.
School District

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

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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*

Adopted on: February 22, 2011

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