POUDRE SCHOOL DISTRICT

Authorization for Disclosure of Protected Health Information

I authorize _____
(Provider name)
_____to release the health
(Provider address)
information of the individual named below.

Patient/Student Name _____ DOB _____
Address _____
Phone Number _____ Parent Name _____

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Name _____ Organization_____
Address _____

For the purpose of: _____

The type and amount of information to be disclosed is as follows: *(specify dates where appropriate):*

- Entire medical record, from date _____ to date _____.
- Summary statement of diagnostic testing and treatment plan, from date _____ to date _____.
- Laboratory Result, from date _____ to date _____.
- Immunizations records, from date _____ to date _____.
- Well-child exam, from date _____ to date _____.
- Dental exam, from date _____ to date _____.
- Developmental reports and evaluations, from date _____ to date _____.
- Other: _____
  (You must specifically indicate the release of records relating to drug or alcohol abuse, child abuse, HIV status, genetic testing, or mental health records. A separate authorization form is required for release of psychotherapy notes.)
- Verbal consultation as needed with _____

I understand this authorization will expire, without my express revocation one year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that I have a right to a copy of this authorization.

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on obtaining the individual's authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and once the information is disclosed, it may no longer be protected by federal HIPAA confidentiality rules.

_____
Signature of Patient or Authorized Personal Representative Date

_____
Personal Representative's Name (print) and Relationship Date

This authorization reflects the requirements of HlPAA, 45 C.F.R.J 164.508.