

FERNDALE AREA SCHOOL DISTRICT

100 Dartmouth Avenue
Johnstown, PA 15905

Authorization for Release of Protected Health Information

I hereby authorize the use and disclosure of my individually identifiable health information as described below.

I understand that signing this Authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan.

I understand that I am entitled to receive a copy of this form upon signing it.

I understand if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this Authorization, but that I must send a written revocation to the address below.

I also understand that the revocation applies to uses and disclosures made after the revocation is made.

Patient Name: _____ Employee Name: _____

ID Number: _____

Person or organization authorized to RELEASE my health information: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Specific description of information is to be disclosed (be specific, include dates): _____

The authorization will expire on (date or event): _____

What is the purpose of the disclosure: _____

Signed: _____

Date: _____

Patient Name (Print): _____

If signed by a patient representative, please print Representative Name: _____

Relationship to patient, including authority for status of representative: _____

*****YOU MAY REFUSE TO SIGN THIS FORM*****

This form does NOT authorize the release of psychotherapy notes.

This form does not constitute advice and is provided "as is". This form is based upon current federal law and is subject to change based upon changes in federal law or subsequent interpretive guidance. This form must be modified to reflect state law where state law is more stringent.