Request for Protected Health Information

> This form may be used to grant release of a patient's protected health information by the health care provider for an employee or student for purposes 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): _____

_____

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. **NOTE:** Redisclosure of HIV information shall comply with KRS 214.181 and KRS 214.625, which impose additional limitations on release of such 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 Legally Recognized Representative   *Date*

_____   _____
Name of Patient or Legally Recognized Representative   *Legally Recognized Representative's Authority*

Review/Revised:6/25/13