AUTHORIZATION FOR RELEASE OF INFORMATION

(HIPAA)

SECTION A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization 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.

PATIENT NAME: _____ **MISD ID#** _____

Persons/Organizations providing the Information: {Physician/Hospital name, address, phone number, fax number)

_____

_____

Person/Organizations receiving the information: **Mesquite ISD Personnel Services**

Specific description of information {including dates) Reason for request:

_____

_____

_____

SECTION B: Must be completed only if a health plan or<! health care provider has requested the authorization

1. The health plan or health care provider must complete the following:
   a. What is the purpose or the use of disclosure? _____
   b. Will the health plan or health care provider requesting *the* authorization receive financial or In-kind compensation in exchange for using or disclosing the health Information described above? Yes_____ No_____
2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials** _____
   b. I understand that r may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign It. **Initials**_____

SECTION C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire_____/_____/_____(date/month/year) **Initials**_____
2. I understand that I may revoke this authorization at any time by notifying the providing organization In writing, but if I do, it will not have any effect on any actions they took before they received the revocation. **Initials**_____

Signature of Patient or Patient's Representative: _____ Date_____

Form MUST be completed before signing.

Printed name of Patient's Representative: _____

Relationship to the Patient: _____

Requested paperwork cannot be processed without your signature.

Return this form only to:
Personnel Services
Rhonda Ferrin
RFerrin@mesquiteisd.org
Fax Number: 972-882-7799
3819 Towne Crossing Blvd.
Mesquite, TX 75150

NOTARY:

Subscribed and sworn to before me this_____day of_____20_____

_____, **Notary Public**

Date_____

My commission expires _____