AUTHORIZATION FOR RELEASE OF INFORMATION  
(HIPAA)

SECTION A: Must be completed for all authorizations

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)

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Person/Organizations receiving the information: Mesquite ISD Personnel Services

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

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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 I 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 __________