Wimberley ISD
Strength. Innovation. Excellence.

Authorization to Use or Disclose Health Information

Patient Name: _____ Phone #: _____

Date of Birth: _____SS #: _____ Medical Record Number: _____

☐ I authorize the use or disclosure of the above named individual's health information as described below:

The following individual(s) or organization(s) are authorized to make the disclosure:

☐ Information may include diagnostic test results, provider notes, visit notes and other material of importance for health and safety at school

☐ I understand that my authorization may include Behavioral Health Information

The information identified above may be used by or disclosed to the following individual or organization(s):

Name: _____

Address: _____

This information for which I'm authorizing disclosure may be used for the following purpose:

____ Sharing with other health care providers/school personnel as needed

____ Other (please describe): Development of an individual education plan/school nursing care plan

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☐ I understand that I have a right to revoke this authorization at any time.

☐ I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department.

☐ I understand that the revocation will not apply to information that has already been released in response to this authorization.

☐ I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

☐ I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient_____

_____

Signature of witness Date

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