

East Dubuque Unit School District #119

East Dubuque, Illinois 61025

www.edbqhs.org

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED EDUCATIONAL AND HEALTH INFORMATION

Patient Information

Name (Last, First MI)

Street Address

City

State

Zip

Phone Number () _____ Date of Birth _____

I hereby authorize East Dubuque School District to:

☐ Disclose information from my health record to: _____

☐ Obtain information from: _____

☐ Verbal exchange with: _____

Name (Health Care Facility, Physician, Insurance Co, Attorney, Self, etc.)

Street Address

City

State

Zip

Phone Number/Fax Number

Please check one:

☐ Mail Records

☐ Fax Records

☐ Will Pick up Records

☐ No Records needed at this time, file in patient's health care record for future use

This authorization will expire in twelve months from the date of my signature on page 2 and will not include records past that date unless otherwise specified below.

The information to be disclosed will cover the time period from _____ to _____.

Over →

State and Federal Laws require specific authorization prior to disclosing certain information. Please check if you would like any or all of the following information disclosed:

☐ Mental Health ☐ Alcohol/Drug Use ☐ Developmental Disability

Type of information to be disclosed (Check all categories that apply)

☐ Clinic Notes ☐ Hospital Notes ☐ Lab Results
☐ Medication List ☐ Problem List ☐ Immunization List
☐ Allergy List ☐ OT/PT Notes ☐ Psych/Social Worker Notes
☐ Hearing Notes ☐ Vision Notes ☐ IEP
☐ Behavior Notes ☐ Other, please specify _____

By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may be conditioned on you signing this authorization. When information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive a copy of the material to be disclosed. This authorization may be revoked in writing at any time prior to the disclosure of this information. Copies of records may be obtained with reasonable notice and payment of copying costs.

Signature of Patient: _____ **Date:** _____

Signature of Parent/Guardian _____ **Date:** _____
(If signed by a person other than the patient, please state relationship and authority to do so.)

Patient is:
☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority:
☐ Legal Guardian ☐ Biological Parent of Minor ☐ Adoptive Parent
☐ Health Care Agent ☐ Personal Representative of Deceased ☐ Spouse of Deceased
☐ Other: _____

District Office 200 Parklane Drive P: (815) 747-2111 F: (815) 747-3369	High School & Junior High 200 Parklane Drive P: (815) 747-3188 F: (815) 747-3516	Elementary School 100 School Road P: (815) 747-3117 F: (815) 747-3827
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