Authorization for Use and/or Disclosure Of Protected Health Information to Schools

MEDICAL RECORD #: ______________

PATIENT INFORMATION (Please Print):

Last Name | First Name | Middle Initial | Maiden Name (if applicable) | Gender

Address | City | State | Zip Code | Phone Number

Date of Birth | Social Security Number | Email Address (optional)

Please check/specify the following type of information, including dates of treatment, that you want to be disclosed pursuant to this Authorization. Failure to specify will render this Authorization invalid.

Dates of Treatment/Particular Illness/Admission Requested:______________________________

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Educational Evaluations
- ☐ Speech and Language Evaluations
- ☐ Occupational Therapy/Physical Therapy Evaluations
- ☐ Hospital School Attendance
- ☐ School Recommendations
- ☐ Academic/Educational Information
- ☐ Other ______________
- ☐ Other ______________
- ☐ Other ______________
- ☐ ALL INPATIENT MEDICAL RECORDS (See Note)
- ☐ ALL OUTPATIENT MEDICAL RECORDS (See Note)

Purpose for Disclosure

☒ School

The purpose of the use and/or disclosure of this information is to best provide for the student's educational, physical and emotional adjustment between the hospital setting and the school setting.

Disclose Records To:	
Name	
School	
Title	
Street Address	
City, State, Zip	
Telephone Number	

Records may be:
- ☐ Mailed
- ☐ Reviewed only
- ☐ Faxed
- ☐ Picked up by Whom: ______________________
- ☐ In-Person Meeting
- ☐ Shared by Telephone

This Authorization will expire 60 days after the date below, or sooner by my choice, in which case, Authorization will expire on ______________, or ______________________ (event) occurs. This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department, 636-8233. Please refer to Cincinnati Children's Hospital Medical Center's (CCHMC) Notice of Privacy Practices.

CCHMC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations. I understand that a standardized fee has been established for copies of medical records. Please inquire regarding these fees prior to requesting copies.

I, the undersigned, hereby authorize Cincinnati Children's Hospital Medical Center to use and/or disclose information from my (or give relationship) ______________________ medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

Signature: ______________ **Date:** ______________ ☐ **Patient** ☐ **Parent** ☐ **Legal Guardian**

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If CCHMC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

Request Has Been Fulfilled: ☐ **Yes, Initials** ________ **Date** ____________