OnTECH Charter High School

Authorization for Use and Disclosure of Health Information

Name ____ Date of Birth ____________________________

By signing this form, I hereby authorize ____ to disclose the health information described below to ____

(Name and Address of Person or Organization)

(Check All That Apply):

____ All health information

____ Health information relating to the following treatment or condition ______________________________________

____

____ Health information for the date(s) ____________________________________

____ Other specific description ____

Reason for This Authorization:

____ At my request

____ Other (specify) ____

This authorization expires on ____

(Date or Description of Event)

This information has been disclosed to you from confidential records, which are protected by federal and/or state laws. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure of these laws may result in fines, civil penalties and/or imprisonment. A general authorization for the release of medical or other health information is NOT sufficient authorization for further disclosure of this information.

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested to the Privacy Officer and the health care provider listed above.

____ ____________________________________

(Patient/Legally Authorized Representative) (Date)

____ ____________________________________

(Printed Name) (Relationship to Patient)

Note: This document must be made a part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.

Employee Name: ___________________________ **DOB: ________________**

I hereby authorize the OnTECH Charter High School to obtain information from:

Agency Name:	Agency Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Staff Member Title (if known):	Staff Member Title (if known):
Agency Name:	Agency Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Staff Member Title (if known):	Staff Member Title (if known):

I hereby authorize the OnTECH Charter High School to release information to:

Agency Name:	Agency Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Staff Member Title (if known):	Staff Member Title (if known):