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	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 1 year 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 _____