Grace School District No.148
HIPAA Authorization Form
for the Release of Protected Health Information (PHI)

At my request, I authorize Grace School District No. 148 (hereinafter "School District") to disclose protected health information (PHI) as described below.

Name:_____ Date of Birth: _____

Street Address: _____

City/State/Zip: _____

Telephone Number: _____

Person or Organization Receiving the Information:

Name: _____

Street Address: _____

City/State/Zip: _____

Telephone Number: _____

Description of specific information to be disclosed: _____

_____

_____

_____

The date or event when this authorization expires: _____
(If not specified, this authorization will expire one year from the date of signature.)

I understand that if the person or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations, the person or organization may not be obligated by state or federal law to protect it.

I understand that I may cancel this authorization in writing at any time by sending a written request to the School District offices. My cancellation of this authorization will not affect any action the School District took prior to receiving my cancellation request.

This authorization is voluntary. The School District will not condition my enrollment in the health plan or eligibility for payment of benefits on receiving this authorization.

Date: _____

Signature: _____
(If signed by a personal representative of the employee, please complete the following.)

Personal Representative's name: _____

Relationship to Employee: _____
(i.e., parent, legal guardian, holder of power of attorney. Please attach legal documentation of relationship other than parent.)