

Authorization to Use or Disclose Health Information

Family Health uses this form to obtain your written authorization to use or disclose your health information.

Patient Name: _____ **Date of Birth:** _____

Purpose of the Disclosure:

- ☐ To share information with school personnel
- ☐ Treatment, Payment, and Health Care Operations
- ☐ Legal Representation or Purposes
- ☐ At the Request of the Patient
- ☐ Other: _____

This Authorization expires:

- ☐ One (1) year from the date it is signed
- ☐ Other (e.g., conclusion of legal proceedings): _____

I authorize the disclosure of my health information to:

☐ **My treating providers** (Family Health Services may also request health records from other providers for continuity of care purposes, in order to coordinate and support your ongoing treatment. Please write the name of the recipient health care provider or health care organization on the line provided): _____

School-Based Health Clinic Locations:

- ☐ Greenville Elementary School District: 1111 N. Ohio St., Greenville, OH 45331
- ☐ Greenville Middle School District: 1111 N. Ohio St., Greenville, OH 45331
- ☐ Greenville High School District: 100 Greenwave Way, Greenville, OH 45331
- ☐ Tri-Village Local School District: 315 S. Main Street, New Madison, OH 45346
- ☐ Anthony Wayne Preschool: 4932 Children's Home-Bradford Road, Greenville, OH 45331
- ☐ Ansonia Local School District: 600 East Canal Street, Ansonia, OH 45331
- ☐ Mississinawa Valley Elementary District: 10480 Staudt Road, Union City, OH 45390
- ☐ Mississinawa Valley Jr. High/High School District: 10480 Staudt Road, Union City, OH 45390
- ☐ Other School District: _____

I authorize Family Health, to use or disclose the following health information for the date(s) listed below (please check the type of health information for which you authorize disclosure and list the date(s) for which you authorize disclosure):

☐ Complete Health Record - OR -

- | | | |
|--|---|--|
| ☒ Progress Notes- Annual Wellness/Well Child Visit | ☐ Treatment Plan(s) | ☐ Discharge Summaries |
| ☒ Immunization Record (s) | ☐ Intake/Clinical Evaluation(s) | ☐ Current Diagnoses |
| ☒ Operative Reports | ☐ Therapist Progress Note(s) | ☐ Medication Order Sheet(s) |
| ☒ Laboratory Reports | ☐ Psychiatric Evaluation(s) | ☐ Other: _____ |
| ☒ Radiology Reports | ☐ Attendance Participation Summary | |
| ☒ Retinal Eye Exam | ☐ Group Progress Note(s) | |

Records Date Range: _____
(if requesting a specific date)

I further understand that:

- This Authorization extends to all or any part of the health information designated above, which may include records that indicate that I am or have been in treatment for a substance use disorder.
- I may revoke this Authorization at any time (except to the extent that action has been taken in reliance on it) by providing written revocation to Family Health.

- Signing this Authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this Authorization.
- The health information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected upon its release to the recipient. If the recipient is a Covered Entity or Business Associate, then my health information may be redisclosed in accordance with HIPAA, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.
- I may have the right to inspect or obtain a copy of the health information being used or disclosed pursuant to this Authorization.

I have read the above and authorize the disclosure of my health information as stated.

Patient or Authorized Representative (Print Name): _____

Signature: _____ **Date:** _____

If signed by Authorized Representative, specify relationship to Patient: _____

If you are the representative of a patient, select the scope of your authority to act on the patient's behalf:

- | | | | |
|--|--|---|-------------------------------------|
| ☐ Parent | ☐ Legal Guardian | ☐ Surrogate Decision-Maker | ☐ Biological |
| ☐ Power of Attorney | ☐ Executor or Personal Representative | ☐ Other: | |
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This health information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.
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