RISE Charter School

Authorization to Obtain or Disclose Protected Health Information

	Fax
	Mailed
	In Person/ID checked
Staff Initials	

Patient: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

Other names under which the Patient has been treated: _____

RELEASE INFORMATION FROM:		RELEASE INFORMATION TO:	
X			Family Health Services (fax or address below)
	Other (Specify facility and fax or address below)	X	Other (Specify facility and fax or address below)
			RISE Charter School Staff: Principals, Vice Principals, School Counselors, & Instructional Staff

The person(s) or entity(s) listed above may use or disclose information relating to the patient's care during the following time period: Healthcare provided between (*date*) _____ and (*date*) _____.

PURPOSE OF RELEASE:

☐ At Person's Request ☐ Legal ☐ Other _____

☑ Continued Exchange of Confidential Health Information to/from/with above.

INFORMATION TO BE RELEASED:

☐ History, clinic notes, operative reports, hospital records, labs/pathology, diagnostic test results, immunization records, diagnostic images, films or other recordings (*e.g.* X-rays, MRI scans, CT scans, *etc.*)

☐ Charges, billing and payment records, etc.

☐ Psych Evaluation/Assessment/Mental Health Notes

☐ Psychotherapy Notes: Not to be combined with any other information to be released.

☑ Other: (Specify) Coordination of services and care

I understand that I have the right to revoke this authorization at any time except to the extent that RISE has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to: RISE Charter School.

I understand that information disclosed by _____ pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.

This authorization will expire on the following date or event: _____. **If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.**

_____ _____

Signature Date

_____ _____

Authority or Personal Representative Relationship to the Patient

** Give a copy of the authorization to the Patient or Personal Representative.*

Updated 2.27.2018