QUEEN ANNE'S COUNTY PUBLIC SCHOOLS

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of my health information as listed below.

Patient name: _____ **Date of Birth:** _____

Address: _____ **Telephone #:** _____

_____

City: _____ **State:** _____ **Zip Code:** _____

Previous Name: _____

Provider or facility authorized to release information:

Person or company authorized to receive information: **Address**

Queen Anne's County Public Schools _____

_____

Type of Record: ☐ Medical-Dates: _____

Description of information:

☐ Medical Record Abstract ☐ Entire Record ☐ Other_____

(Medical Record Abstract includes: Discharge Summary, Emergency Room Record, History and Physical, Operative Reports, Laboratory Reports, X-ray Reports.

Special Records: Medical Records to be released **will not include** records of drug and alcohol abuse program treatment, mental health treatment or STD, HIV, or genetic information records unless the specific boxes below are checked. This information is protected by special laws. Checking the boxes is not a representation that such information exists.

☐ Include drug and alcohol records ☐ Include HIV records ☐ Include STD records

☐ Include genetic information records ☐ Include mental health records

Purpose of Release of Information:

☐ Personal Use ☐ Medical Treatment/Management ☐ Legal Proceedings

☐ **Employment Related purposes** ☐ Insurance Related ☐ Other _____

1. This authorization will expire: **X One year**

2. I understand that I may revoke this authorization at any time by notifying the school nurse at _____ in writing at _____. I understand that revocation will not have any effect on actions QACPS took before they received the revocation.

3. This authorization is voluntary. However, I understand that health care services will not be provided unless I provide an authorization when the purpose of the health care service is to create health information that will be disclosed to a third party (for example, a sports/ illness related physical).

4. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.

_____	_____	_____	_____
Signature of Patient or Patient's Representative	**Date**	**Printed Name of Patient's Representative**	**Relationship to Patient**

To Recipient: *Information regarding drug and/or alcohol use, abuse, treatment or referrals for treatment has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

This box for use by Health Care Personnel Only

Witness to Authorization _____