Authorization to Exchange Health and Educational Information

Patient Name _____ ___ Male ___Female

Medical Record # _____

Address _____
Street City State Zip Code

Phone: (_____) _____ Date of Birth _____ Age _____ Grade _____

_____ I authorize my child to receive services from the HSHS St. John's Children's Hospital Tutoring and Enrichment Program

_____ I authorize use or disclosure of the above named individual's health and educational information as described to be released to the school of agency listed below. The HSHS St. John's Children's Hospital Tutoring and Enrichment Program has permission:

_____ to release to _____ to obtain from _____ to verbal exchange with

School or Agency _____ _____ District _____

Phone (_____) _____ Fax (_____) _____

Teacher/Counselor _____ County _____

Address _____

The following information may be included:

_____ Attendance _____ Educational needs/IEP _____ Admission & Discharge dates
_____ Class Assignments _____ Medical diagnosis _____ Tutoring request

EXPIRATION: This authorization is good until the following date/event _____
OR if this item is left blank, the authorization will expire in one (1) year from the date signed.

PURPOSE: (check all that apply – copy fees may apply)
_____ Patient request _____ Continuing care _____ Legal investigation/Action
_____ Insurance Eligibility/Benefits _____ Other _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the right to inspect and/or receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that if I agree to sign this authorization, I will be provided with a copy of it. I understand that I may be charged a fee for record copies. I understand that I am under no obligation to sign this form. Treatment, payment enrollment or eligibility for benefits may not be based upon my decision to sign this authorization. Authorization may be needed to release information to payers for certain mental health services and/or HIV testing. If I refuse to sign the

authorization form for this purpose I understand that I may be responsible for paying the entire bill for these services. I also understand that I may revoke this Authorization at any time by notifying the authorizing provider's health information department, as listed above, in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I understand that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

This release was _____ Signed in person _____received via telephone with 2 witnesses listed below
_____ returned via mail

_____ _____
Signature or patient or legal representative Date

_____ _____
Signature of patient or legal representative Date

If signed by a person other than the patient, complete the following:

1) Individual is: _____ a minor _____ legally incompetent or incapacitated
_____ deceased
2) Legal authority: _____ parent _____ legal guardian
_____ activated POA for Health Care
_____ next of kin/executor of deceased

_____
Signature of witness(s) who can verify patient identity

By signing above, I hereby declare that I have not been denied physical placement of this child.

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