THORP SCHOOL DISTRICT

AUTHORIZATION FOR *RELEASE* OF HEALTH CARE INFORMATION

Patient Name _____ **Birthdate** _____

I authorize the release of the healthcare information described below to be released from and sent to the following:

Information to be released FROM: _____
Name of facility or provider

Information to be released TO: **THORP SCHOOL DISTRICT**
P.O. Box 150
Thorp, Washington 98946
Phone 509·964·2107 Fax 509·964·2313

Specific information to be released: _____

_____

_____

Purpose for which disclosure is being made: _____

_____

_____

Specific Minor Patient Authorization:
If the patient has reached the age below, only the patient can authorize disclosure relating to the following:

- ☐ HIV/AIDS, STDs status, diagnosis, treatment (consent may be given by student 14 years of age)
- ☐ Family planning/abortion (consent may be given by any age student)
- ☐ Alcohol/drug treatment (consent may be given by student 13 years of age)
- ☐ Mental health services (consent may be given by student 13 years of age)

My Rights

I understand I have a right to request and receive a Notice of Privacy Practices. I may inspect and receive a copy (a nominal fee may be charged). Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing the authorization. I may revoke this authorization in writing by presenting it as provided in the Notice of Privacy Practices for the Facility, but the revocation will not apply to information already used or disclosed. I understand that once the health information I authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time, it may no longer be protected under Privacy laws. The provider must make the healthcare information available within 15 working days after receiving the request or notify the patient of any delay (RCW 70.02.080).

Expiration date: _____

_____ _____
Signature of patient/legal representative Date

_____ (___)_____
Relationship to Patient Phone number

Copies: Parent/Guardian or student School official requesting/receiving the protected health information