Authorization for Use and/or Disclosure of Protected Health Information to Schools

Patient Information (Please Print):

Last Name	First Name	Middle Initial	Gender

Address	City	State	Zip Code	Phone Number

Date of Birth	Email Address (optional)

The following type of information may be disclosed pursuant to this Authorization:

- ☐ History & Physical
- ☐ Educational Evaluations
- ☐ Speech and Language Evaluations
- ☐ Occupation/Physical
- ☐ Therapy Evaluations
- ☐ School Recommendations
- ☐ Academic/Educational Information
- ☐ Screening Labs
- ☐ Other_____
- ☐ Other_____
- ☐ All Outpatient Medical Records (see note)

Purpose for Disclosure: ■ School

The purpose for the use and/or disclosure of this information is to best provide for the student's educational, physical and emotional adjustment between the hospital setting and the school setting.

Disclose Records To:	
Name	
School	
Title	
Street Address	
City, State, Zip	
Telephone #	

Records may be (mark all that apply): □ Mailed □ Faxed □ Shared by Telephone

This Authorization will expire at the end of the school year, or sooner by my choice, in which case, Authorization will expire on _____, or _____ (event) occurs. This Authorization may be revoked at any time to the extent that use and/or disclosure have not already occurred prior to your request for revocation. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to Performance Pediatrics.

Performance Pediatrics will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations. I understand that a standardized fee has been established for copies of medical records. Please inquire regarding these fees prior to requesting copies.

I, the undersigned, hereby authorize Performance Pediatrics to use and/or disclose information form my (or give relationship) _____ medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

_____ □ Patient □ Parent □ Legal Guardian

Signature Date

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 15 years of age, he/she is required to sign this Authorization. If Performance Pediatrics requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the Individual completing this form.