General Authorization for Use or Disclosure of Protected Health Information

1. I authorize my physician to release, discuss, or disclose individual information as described below from the records of:

Name: ______________________________ Date of Birth: ____________________

Telephone: ______________ Address: ____________________________________

2. Reason for disclosure: Individual is looking to receive homebound instruction. The District needs to be provided with access to health information in order to properly administer the homebound instruction program. (Description of each specific purpose – if disclosure is at individual's request and information to be disclosed does NOT include drug and alcohol treatment information, may state, "At the request of the individual")

3. I understand that:

a. This authorization may be revoked at any time by writing to the individual/organization identified in section 1 except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent further disclosure.

b. The Department and its health and human services programs will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.

c. Information disclosed pursuant to this authorization may be subject to re-disclosure by the individual/organization identified in section A.2 below and is no longer protected by federal privacy regulations.

d. The Department, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

e. I may refuse to sign this authorization.

PART A – General Health Information

A. 1 Information to be disclosed (Identify specifically the Protected Health Information to be Used/Disclosed. If information to be used or disclosed includes mental health, drug and alcohol, or HIV-related information, please complete section on back of this form that relates to that information)

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A. 2 This information is to be disclosed to:

Upper Perkiomen School District

(Insert name or title of the individual/organization to which disclosure is to be made)

A. 3 This authorization expires as indicated:

________ Once acted upon

________ Other (Specify date or event) ______________________________

(Continued on reverse side)

PART B- Special Categories of Medical Information

B. 1 Drug and Alcohol Information

If my medical record includes drug and alcohol information, I want to send that information to the individual/organization identified in Part A of this form.

______Yes ______ No

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part2). The Federal rules prohibit the individual/organization identified in Part A of this form from making any further disclosures 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.

B. 2 Mental Health Information

If my medical record includes mental health information, I want to send that information to the individual/organization identified in Part A. of this form.

_____Yes _____ No

B. 3 HIV/AIDS Information

If my medical record includes HIV/Aids information, I want to send/discuss that information to the individual/organization identified in Part A of this form.

_____Yes _____No

This information will be disclosed from records protected by Pennsylvania Law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

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Signature of Individual or Personal Representative Date

If personal representative, state relationship to individual:

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Signature of Witness Date

If individual is physically unable to sign. Signature of second witness:

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