McGUFFEY SCHOOL DISTRICT
Special Services Office
P.O. Box 421, 119 Main Street
Claysville, PA 15323
(724)663-5364 **Office** (724)663-3696 **Fax**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize ____ to release information from the record of:
Name of Facility/Person

____ __________________________ ____________________ to
Patient Name | Birth Date | SSN/MR #

____ _(______)_____________________ __(______)___________________
Name of Facility/Person | Phone | Fax

____
Facility/Person Address

for the purpose of (**PROVIDE A DETAILED DESCRIPTION**): ____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released **and** approximate date(s) of service (check all that apply):
   Inpatient Physician Office/Clinic Dates:____
   Outpatient Emergency Dept

I authorize the release of (Check all that apply) _____Mental Health Information ____ Drug and Alcohol Information, contained in the records indicated above.

2. Specific information to be released (check all that apply):
   Consults Medical History & Physical Exam Physician Orders
   Discharge Summary Notes Psychiatric/Psychological Eval Progress Notes
   Medical Records-(Please Specify records to be released)____
   Telephone/Oral Communication: (Please specify information to be shared):______________________________
   Other:____

I understand that this Authorization is effective for a period of 365 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. See side two of this form for additional patient rights and responsibilities.

If applicable, specify other expiration date/event here ____

____________________ ____
Date of Signature | Signature of Patient (14 years of age or older may authorize release of mental health information. A minor can authorize release of drug & alcohol treatment without parental consent.)

____________________ ____
Date of Signature | Signature of Parent, Legal Guardian or Authorized Representative

Relationship to Patient:

Parent with Parental Rights *(not sufficient for substance abuse records)*
Registered Kinship Care Relative *(not sufficient for substance abuse records)*
Court Appointed Guardian
Legally Appointed Healthcare Agent *(not sufficient for substance abuse records)*
Medical Power of Attorney *(not sufficient for substance abuse records)*
Power of Attorney with Right to See Medical Records *(not sufficient for substance abuse records)*
Surrogate Decision Maker *(not sufficient for substance abuse records or mental health records)*
Court Appointed Personal Representative of Deceased

__________________ ____

Date of Signature Witness/Staff Member Signature

Additional Patient Rights and Responsibilities

- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that received the records may re-disclose the information, therefore (1) McGuffey and its staff/employees have no responsibility or liability as result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule (HIPAA), however, such information is always protected by the drug and alcohol regulations.
- My Decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.
- Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing the authorization.