Greeneville City Schools
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Student Name: _____ Date of Birth: _____
Address: _____ Phone #: _____
City: _____ State: _____ Zip:_____
To be completed by the requestor: ___ Pick up ___ Mail ___ Fax ___ Other: _____

The following individual or organization is authorized to make the following disclosure:

☐ Greeneville City Schools
P.O. Box 1420
Greeneville, TN 37744

☐ Other: Name: _____
Address: _____
City: _____State: ____Zip_____

Information Requested:

___ *Abstract ___Discharge Summary ___Operative Report ___Emergency Room Report
___ Pathology Report ___ History & Physical ___ Laboratory Report ___ Radiology Report
___ Consultation ___ Billing information ___X-ray Reports (Specify) _____
___ Other: _____

Reason for requesting information: _____
Requests may be subject to copying fee
NOTE: *If this form authorizes use and/or disclosure of psychotherapy notes, it may not be used to authorize the use and/or disclosure of any other protected health information. A separate Authorization is needed for any other use and/or disclosure.*

This information may be disclosed to and used by the following individual or organization:
Name: _____
Address: _____
City: _____ State: _____ Zip:_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Coordinated School Health Department of Greeneville City Schools. I understand that the revocation will not apply to Information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 90 days): _____.
If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making the disclosure.
I understand that the information in my health record may include psychiatric, alcohol or drug abuse/testing information, which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV and/or sexually transmitted disease.

_____ _____ _____
Signature of Patient or Appropriate Personal Representative Date Witness

_____ _____ _____
Printed name of Personal Representative Relationship Phone

_____ _____
Address of Personal Representative City, State, Zip

**Abstract consists of facesheet,history & physical, consults, operative notes, emergency record, lab, radiology, EKG's , pathology, physical therapy and rehabilitation (if available).

Written 4/08