Request for Protected Health Information

> This form should be used when release of a patient's protected health information is being made to the health care provider for an employee or student for a purpose other than treatment, payment or health care operations.

I, ____________________________________, hereby authorize __________________________
Name of Employee, Student 18 or older, or Parent/Guardian *Name of Physician/Practice*

to use and/or disclose my protected health information described below to Potomac SD 11.

My protected health information will be used or disclosed upon request for the following purposes (name and explain each purpose): ____

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This authorization for use and/or disclosure applies to the following information (please mark those that apply):

- ☐ Any and all records in the possession of the above-named physician or physician's practice, including mental health, HIV, and/or substance abuse records. (Please cross out any item you do not authorize to be released.)
- ☐ Records regarding treatment for the following condition or injury ______________________________ on or about________________________.
- ☐ Records covering the period of time ______________________ to ________________.
- ☐ Other (Specify and include dates.)____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to above-named physician/practice. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that the above-named physician/practice may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on the following date or event: _______________________________.

I certify that I have received a copy of this authorization.

____ ______________________
Signature of Patient or Personal Representative *Date*

____ ______________________________
Name of Patient or Personal Representative *Personal Representative's Authority*

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