*Freeburg Community High School District #77*

**AUTHORIZATION AND RELEASE FOR MEDICAL RECORDS**

TO: THE FOLLOWING HEALTH CARE PROVIDERS:

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|---|---|
| **PROVIDER NAME:** | |
| **ADDRESS:** | |
| **PHONE NUMBER:** | |

As the parent(s)/guardian(s) of:

| | |
|---|---|
| **STUDENT NAME:** | |
| **ADDRESS:**<br><br>**PHONE NUMBER:** | |
| **DATE OF BIRTH:** | |
| **PARENT/GUARDIAN NAME** | |

For educational purposes only, I hereby authorize disclosure of my child's confidential health information/records, and for you to communicate with orally and/or in writing regarding such information/records, from the above-referenced hospital, clinic, health care facility, or any other health care provider, and any physician and staff person who has attended, treated or examined me, to provide copies of any and all recorded information concerning me and/or my protected health information, including but not limited to complete copies of all medical records, physician's records, therapy log/notes, surgeons' records, x-rays, CAT scans, pathology materials, slides, tissues, laboratory reports, discharge summaries, progress notes, consultants, prescriptions, records of drug abuse and alcohol abuses, physicals and histories, nurses' notes, correspondence, insurance records, consent for treatment, states of account, bills, invoices, or any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, diagnosis or other information pertaining to and concerning my mental and physical health condition to the following recipient (hereinafter "Recipient"):

**Freeburg Community High School District No. 77**
**401 S. Monroe Street**
**Freeburg, IL 62243**

The purpose of this release of information is for use by the above-referenced entity and its agents and authorized employees (collectively "Recipient"). This information is to be used to assess when I can return to work and/or any accommodations I may need for my employment with the Recipient.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. This authorization does not authorize you to provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.
I have full knowledge and understand that:

| Student Name: | Date of Birth: | School: |
|---|---|---|
| | | |

1. By signing this authorization, I am authorizing the release Authorization and Release for Medical Records, Including But Not Limited to Drug and Alcohol Treatment Records and Psychiatric, Psychological, and Mental Health Records ("this authorization"), the release of my confidential health information/records pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to the above-referenced Recipient, including all documents and communication from a therapist, doctor, or hospital which may be deemed mental health records under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110/1 *et seq*.

2. By signing this authorization, I am requesting and allowing the release of my confidential health information/records to the above-referenced Recipient.

3. By signing this authorization, I understand that the specific information to be disclosed in my confidential health information/records may include information regarding (a) drug and alcohol abuse or use of such; and (b) counseling referrals. Moreover, I fully understand that this information is specifically protected by federal regulations including 42 CFR 2[1]) and that by signing this authorization I am allowing the release of any drug and/or alcohol information records and/or counseling referrals to the above-referenced Recipient.

4. By signing this authorization, I understand that there is a potential that information disclosed pursuant to this authorization may be subject to re-disclosure by the Recipient and may no longer be protected by HIPAA.

5. I understand that I can revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it. I understand that any revocation of this Authorization must be in writing and addressed to the provider identified above.

6. **This authorization expires one year after it is signed, or until I revoke my signature, whichever occurs sooner.**

I hold the above-named Recipient (including but not limited to its employees and agents) harmless from any and all damages, which might result, to myself and to, my relatives or heirs from the use of this information being disclosed to the above-referenced Recipient. This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof. This authorization also includes the authority to copy and inspect any and all such records. A copy of this release shall be considered to have the same authority as an original.

**INFORMATION IS TO BE RESTRICTED TO THE PERSON NAMED ABOVE.**

**SIGNATURE**
**TODAY'S DATE**

_____ _____

(PARENT/GUARDIAN)

**TO BE SIGNED BY STUDENT AGE 12 OR OLDER IF MENTAL HEALTH REGARDS ARE BEING RELEASED:**

_____ _____

(STUDENT)

[1] *THE FOLLOWING APPLIES ONLY TO DRUG AND/OR ALCOHOL ABUSE/TREATMENT INFORMATION RECORDS published on Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.*