Baltimore County Public Schools

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

NAME OF STUDENT	DATE OF BIRTH	SOCIAL SECURITY NO.	SCHOOL

BY MY SIGNATURE BELOW, I AUTHORIZE ____ TO DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION ("PHI") TO ____.

PHI REQUESTED:

RECIPIENT OF PHI	ADDRESS	CITY STATE ZIP
RECIPIENT OF PHI	**ADDRESS**	**CITY STATE ZIP**

FOR THE FOLLOWING PURPOSES:

This authorization will expire on the following date: ____________________________. The expiration date can be no longer than one year from today's date. If I fail to specify an expiration date, this authorization will expire in one year.

I understand that I may revoke this authorization in writing at any time, except to the extent that Baltimore County Public Schools' employees or agents have acted upon this authorization. My written revocation must be submitted to:

Privacy Officer
Baltimore County Public Schools
ADDRESS
CITY STATE ZIP

- I understand that if the organization authorized to receive information is not a health plan or health care provider and if such information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations, but may be protected under Maryland Law.

- I understand that authorization is voluntary.

- I understand that I may receive a copy of this form after I sign it and that I may inspect and request a copy of the information I am authorizing for use/disclosure.

SIGNATURE OF PATIENT/PATIENT'S REPRESENTATIVE	RELATIONSHIP TO PATIENT
PRINT NAME	**DATE**