Dauphin County Technical School

AUTHORIZATION FORM
FOR THE USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Student or employee Name: ___________________________
Student or Employee ID#: _____________________________

Persons/schools providing the information:

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____

Persons/schools receiving the information:

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____

Specific description of information (including dates)

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What is the purpose of the use or disclosure?:____

____

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____

(**Note**: "at the request of the individual" is a sufficient description of the purpose when the student or employee initiates the authorization and elects not to provide a statement of the purpose.)

Section B: Must be completed only if the healthcare provider has requested the authorization

1. The provider must complete the following statement:

   a. Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes______ No______

2. The student or employee must read and initial the following statement:

   a. I understand that I get a copy of this form after I sign it.
   Pt. initials:________

Section C: Must be completed for all authorizations

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions:

1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment.

2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

Pt. initials:_________

I understand that this authorization will expire on the following date___/___/____ (D/MM/YR) or with the following event:

____

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Pt. initials:_________

____

Signature of student or employee or student or employee's representative

Date: __________

(Pertinent sections of the Form MUST be completed before signing.)

Printed name of student or employee's representative:____

Relationship to the student or employee:____

Privacy Officer:______________________________ **Date:** _________________