AUTHORITY TO RELEASE MEDICAL RECORDS/INFORMATION

I hereby authorize the use and disclosure of my medical records and/or individually identifiable health information as described below. I understand that this authorization is voluntary.

Name of Patient: _____ S.S. Number _____

Address: _____

I hereby authorize _____ **[insert name of health care provider who conducted medical examination]**, its/his/her Director or designee, or Medical Records Department, to furnish and release to _____ **[insert name of persons/school corporation authorized to receive information]** all information, including protected health information (PHI) as defined in the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations, and records concerning, but not limited to, findings, treatments, and opinions as to whether I am able to perform the essential functions of my job with _____ **[insert name of board of school trustees]**, with or without reasonable accommodation, in a safe manner for myself, my colleagues, and/or the students I supervise. I understand that this information shall be released for the specific purpose of allowing my employer to determine whether I am capable of performing the essential functions of the position for which I **( ) am being ( ) am** employed by the _____ **[insert name of board of school trustees]**, with or without reasonable accommodation, and/or to determine the nature of any reasonable accommodations I might require in order to perform the essential functions of my job.

I expressly waive all provisions of law (including, but not limited to, the privacy provisions of the HIPAA) forbidding any physician or other person who has heretofore treated, attended, or examined me, or who may hereafter treat, attend, or examine me, from disclosing any knowledge or information, including PHI, which they thereby acquired. **The foregoing authority shall continue in force until revoked by me in writing.** This release includes the release of any medical records and PHI generated directly and specifically by _____ **[insert name of employee's health care provider]** as a consequence of the examinations conducted by him/her, as well as medical records and PHI obtained from examination(s) by other consulting physicians and/or specialists.

The information transmitted to _____ **[insert name of persons/organization/school corporation authorized to receive information]** may be shared with my employer in a confidential manner consistent with the provisions of the Americans with Disabilities Act (ADA).

I further authorize _____ **[insert name of employee's health care provider]** to discuss the content of any medical records released pursuant to this document with the _____ **[insert name of persons/position in the school corporation authorized to receive information]**.

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I understand that the information used or disclosed may be subject to re-disclosure by the recipient(s) authorized above and may no longer be protected by the Federal privacy regulations. I understand that the health care provider will not condition treatment or payment on my signing of this authorization. I understand that I may generally revoke this authorization at any time by notifying the health care provider in writing. However, I may not revoke this authorization to the extent that the health care provider has taken action in reliance upon the authorization. I understand that I will receive a signed copy of this authorization.

I understand my rights and hereby authorize the use or disclosure of my individually identifiable health information as set forth herein.

Date: _____ _____
Employee's Signature

SWORN TO ME and subscribed in my presence this _____ day of _____, 20____.

_____
Notary Public

A photostatic or electrostatic copy hereof shall have the same authority as the original.

5/1/12

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