BROKEN BOW PUBLIC SCHOOLS
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORATMION

I hereby authorize my physician and/or administrative and clinical staff to disclose the following protected health information to an authorized representative of the Broken Bow Public Schools: _____

_____
(specifically and meaningfully describe the protected health information to be disclosed, such as date of service, type of service, level of detail to be released, etc.)

This protected health information is being used for the following purposes:_____

_____
(list specific purposes her. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose).

This authorization shall be in force and effect until _____
(specify either a date or event that related to the patient or the purpose of the use or disclosure)
at which time this authorization to use or disclose this protected health information expires in 6 months.

I understand that I have the right to revoke this authorization at any time by sending a written notice to my physician's office.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law.

_____
Employee Printed Name

_____ _____
Signature of patient or patient's representative Date

Printed name of patient's representative: _____

Relationship to patient: _____

Approved: 11/10/2015 Reviewed: Revised: