Bethalto Community Unit School District #8
101 School Street, Bethalto, IL 62010
618-377-7200 xt. 17215 618-551-7674

Authorization for Disclosure of Protected Health Information

_____ _____ _____
(Patient Name) (Date of Birth) (Social Security Number)

- **Certification:** I certify that I am (check whichever applies):
  - ☐ The patient, and the identification that I have provided is true and correct.
  - ☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: _____.

I authorize Bethalto Community Unit School District #8 to obtain Protected Health Information (PHI) regarding the treatment; hospitalization and/or outpatient care for my condition from:

Name of Hospital/Doctor: _____
Address: _____
City/State/Zip: _____

- I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse/HIV/AIDS test results or diagnoses.
- Treatment dates covered by this authorization are from preadmission to discharge.

Information To Be Disclosed:

☐ History & Physical Report	☐ Discharge Summary	☐ Consultation Report
☐ Summary Health Info.	☐ Admission Psych Evaluation	☐ Psychosocial History
☐ Physician's Orders	☐ Educational Information	☐ Immunizations
☐ Physical Examination	☐ Psychological Testing	☐ Laboratory Data/X-Ray
☐ Medication Records	☐ Treatment Plans	☐ Integrated Assessment

☐ Discharge Recommendation Letter/Discharge Planning Form
☐ Other: _____

Please send Information:
ATTN: Student Records, Bethalto Community Unit School District #8, 101 School Street, Bethalto, IL 62010.

_____ _____ _____
Date Signature of Patient or Representative Relationship to Patient

_____ _____ _____
Date Signature of Staff Member/Witness Staff Member/Witness Title

- **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days from the date this authorization is signed.
- **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be re-disclosed by the receiving party.

- **Revocation:** I have the right to stop this release of information at any time. Although I understand that I cannot do anything about information already disclosed under this Authorization, I do not want any more information disclosed and I am revoking my authorization.

_____ _____
Signature of Patient or Representative Date Signed

The Bethalto School District understands that as the recipient of confidential health information, which is protected by Federal Law, the district is prohibited from making any further disclosure, unless it is expressly permitted, without the special written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for release of medical or other information is not sufficient for the purpose. Under the provision of Illinois law and/or Federal law, this confidential information is not to be released to other sources without seeking permission of the student and/or guardian to disclose.