COMMUNITY HEALTH & WELLNESS PARTNERS
Care... To Live Life Fully

Phone: 937-599-1411
Fax: 937-599-4128
Email: documents@chwplc.org

SCHOOL-BASED HEALTH CENTER AUTHORIZATION FOR RELEASE OF INFORMATION

By completing this form, CHWP can exchange the requested patient information listed below with the school to better help CHWP care for the patient.

Patient Name:_____ Patient Date of Birth:_____

Name of Person completing Form: _____

Relationship to Patient: _____

I, authorize Community Health & Wellness Partners (CHWP) to request, use, and/or disclose Protected Health Information as indicated below.

☐ Exchange Information With ☐ Request Information From ☐ Send Information To

Name of the School requesting or receiving information:
Address:
City/State/Zip:
Phone/Fax:
Email Address:

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand that my records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on it. In order to revoke the Authorization for Release of Information, I will contact the Community Health and Wellness Partners' Health Information Management Department.

This Authorization will remain in effect for one year after I sign and date this form unless I specify an EARLIER expiration date in the space provided. Early Expiration Date:_____

Notice: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such information by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F. R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

(These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

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Amount of Information to be Disclosed:

☐ Information covering all dates of service (past, present, future)

☐ Information covering the following specified date range: _____(mm/dd/yyyy) to _____(mm/dd/yyyy)

☐ Other (specify the date of treatment or admission/discharge): Date:

_____

The purpose/need of this request is:

☐Communication between the school and CHWP for the patient/student to receive health center services.

☐Other:_____

The following ***INITIALED*** information may be provided by mail, fax, in person, verbally, or by secure email:

_____All of my Health Care Information contained in the description boxes below:

_____All of my Mental Health Information contained in the description boxes below:

_____All of my Substance Use Disorder Information contained in the description boxes below:

INITIAL **beside the information below to be used in partnership with the School**				
_____ School's Class Schedule	_____ CHWP Scheduled Appointment	_____ CHWP Attended Appointment	_____ School's Medication Form	_____ School's Sports Physical Form
_____ Immunization Records		_____ Treatment Diagnosis		
_____ Treatment Recommendation	_____ Medication List/History	_____ Treatment Progress	_____ School's Individual Education Plan (IEP)	_____ School's Evaluation Team Report (ETR)
_____ Other: _____				

Patient Name

Patient Date of Birth

Signature of the Patient

Date of Patient Signature

Print Name of the Person Authorized to Sign for the Patient

Describe Authority to Sign for Patient

Signature of the Person Authorized to Sign for the Patient

Date of Signature

For administrative use only:

Completed by: _____

Needs Faxed? Yes___ or No___

Preferred Delivery Method Paper__ Fax__ Email __ Other:_____

Date Released: _____