AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Fremont High School ("FHS")

PART I Identification

Student's Name_____ Social Security No. or Date of Birth _____

Disclosing Party_____

(Name of Hospital, Clinic, or Doctor)

PART II Authorization for Release of Health Information

I hereby authorize the Disclosing Party and its agents to disclose health information about the Student to FHS.

1. **YOU ARE AUTHORIZED TO DISCLOSE THE FOLLOWING HEALTH INFORMATION**:
   - ☐ Information about a particular admission, treatment or episode of care. Specify: _____
   - ☐ The following health information: _____
   - ☐ All health information about Student and any information requested by FHS

2. **DOES THIS AUTHORIZATION INCLUDE –**
   - ☐ Yes ☐ No Alcohol/drug abuse information if part of the specified record
   - ☐ Yes ☐ No Mental health information if part of the specified record
   - ☐ Yes ☐ No HIV/AIDS-related information (including test results) if part of the specified record
   - ☐ Yes ☐ No Genetic testing information if part of the specified record
   - ☐ Yes ☐ No Psychotherapy notes (Note – You cannot combine an authorization to disclose psychotherapy notes with any other authorization.)

3. **WHAT OTHER LIMITATIONS APPLY**? If none, write "none:" _____

4. **PURPOSE**: What is the purpose of the disclosure? (Note – If the disclosure is at the patient's request, simply state "at the patient's request."): Patient's request.

5. **THIS AUTHORIZATION IS VALID UNTIL**: _____(Note: Unless otherwise stated, I request that this authorization be considered as valid for 12 months from date of signature)

ADDITIONAL TERMS YOU SHOULD KNOW:

1.Not a Condition for Treatment. Refusal to sign this authorization will not affect your ability to receive treatment from the Disclosing Party. 2. Further Uses and Disclosures. Health information to be disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal privacy laws. 3. Right to Revoke. You may revoke this authorization at any time by giving written notice to the Disclosing Party. Your revocation will not be effective to the extent action has already been taken in reliance on your authorization prior to receipt of your written revocation. 4. Photocopies. A photocopy or exact reproduction of this signed authorization will have the same force and effect as the original. 5. Keep a Copy. By signing below, you acknowledge receipt of a copy of this Authorization.

PART III Send Records to FHS at: Activities Office - Attn: Melinda Wearden
Fremont High School
1750 N Lincoln Ave.
Fremont, NE 68025

For Questions Contact: Bill Fitzgerald, Activities Director / Asst. Principal
Phone: (402) 727-3063 Fax number: (402) 727-3977

_____ _____

Signature of Parent (or Student if 18 years of age or Older) Date

_____

Contact Information (Address & Phone)