**Student Services Department**
**Home and Hospital Instructional Services**
9361 S 300 E, Sandy, UT 84070
Telephone: 801-826-5506 Fax: 801-826-5507

# HIPAA Release Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Full Name: _____ Date of Birth: _____/_____/_____

1. I authorize _____ (healthcare provider) to use and disclose the protected health information described below to the Home and Hospital Instructional Services program of Canyons School District.

2. This authorization for release of information covers the period of healthcare from (list dates): _____to _____

3. Extent of Authorization

a. □ I authorize the release of complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of complete health record with the exception of the following:
- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for alternative education services, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____(date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient's parent/legal guardian

_____
Printed name of patient's parent/legal guardian

Date: _____