PLYMOUTH COMMUNITY SCHOOL CORPORATION

HEALTH CARE PROVIDER
AUTHORIZATION FOR RELEASE OF INFORMATION

I here by authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may no longer be protected by Federal privacy regulations.

Name of Patient: _____ SS Number: _____

Address: _____

Persons/Organizations authorized to disclose the information:

Persons/Organizations authorized to receive the information:

Specific description of information (including date(s)):

Specific purpose of the use or disclosure:

Expiration date of authorization: _____

I understand that health care provider will no condition treatment or payment on my signing of this authorization. I understand that I may generally revoke this authorization at any time by notifying the health care provider in writing. However, I may not revoke this authorization to the extent that the health care provider has taken action in reliance upon the authorization. I understand that I will receive a signed copy of this authorization.

I understand my rights and hereby authorize the use or disclosure of my individually identifiable health information as set forth herein.

_____ _____

Signature of Participant or Personal Representative Date

PERSONAL REPRESENTATIVE ONLY

Printed name of participant's representative: _____

Relationship to the participant: _____