AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Date of Birth:_____

I hereby authorize Adena Family Medicine – Ironmen Clinic ("AFM-IC") and Jackson City School District ("JCSD") to share/release/exchange my health information with school nurses, school counselors, school social workers, school athletic trainers and/or teachers and school administrators about my/my child's physical and/or mental condition, including, but not limited to, information regarding services provided to me/my child at school for treatment and care coordination purposes

I understand that this authorization will be effective as of the date signed below and will remain valid throughout my enrollment at JCSD, unless I revoke this authorization sooner. I may revoke this authorization at any time by providing written notice of my intent to revoke to the AFM-IC. If I choose to revoke this authorization, I understand that the revocation will not apply to any information that has been released in good faith prior to the receipt of the written revocation. Any information use and/or disclosed in accordance with this authorization may be subject to re-disclosure by the person or entity receiving the information, and such re-disclosure may no longer be protected by federal privacy laws or regulations.

I also understand that I am not required to sign this authorization and that AFM-IC will not condition participation in the school based health services program, treatment, payment, or eligibility for benefits on this signed authorization, and I have received a copy of the this authorization.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient or Patient's Representative Date

If signed by patient's representative, relationship to patient: _____

(If signed by patient's representative, provide documentation or explanation of your authority to act for the patient. Attached copy, if applicable)