Anderson Hills
PEDIATRICS

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO SCHOOLS AND/ OR DAYCARE FACILITIES

7400 Jager Court
Cincinnati, Ohio 45230-4380
(513) 232-8100 Fax (513) 624-3191

1126 Ohio Pike
Amelia, Ohio 45102-9306
(513) 232-8100 Fax (513) 624-3191

I understand that it is the policy of **ANDERSON HILLS PEDIATRICS** (the "Practice"), to protect the privacy of all of its patients and to follow all state and federal patient privacy laws. However, as a Personal Representative of

PATIENT________________________________(DOB)__________________, who attends (school district/daycare)

____ Phone: (______)______________ FAX: (______)______________

PATIENT________________________________(DOB)__________________, who attends (school district/daycare)

____ Phone: (______)______________ FAX: (______)______________

PATIENT________________________________(DOB)__________________, who attends (school district/daycare)

____ Phone: (______)______________ FAX: (______)______________

I hereby authorize the Practice to disclose certain protected health information to the above-named facility.

□ To comply with a request by the school/ day care.

□ To inform the school/ day care of special medical needs or facts about my minor child.

□ Other: ____

The protected health information that the Practice may disclose is limited to: (Check all the apply):

□ Immunization Record □ Physical/ Athletic Forms □ Permission for Medication Administration

□ Excuse for Absence □ Other: ____

I understand that:

- I have the right to refuse to sign this authorization. If I refuse to sign this authorization, the Practice will in no way deny me my (or my child's) rights concerning treatment, payment for services, enrollment in a health plan or eligibility for benefits.
- I may revoke this authorization at any time after I have signed it by providing the Practice with a written statement of revocation.
  This revocation will be effective immediately upon this Practice's receipt of the written revocation.
- If my child's protected health information is disclosed, then the information may be subject to re-disclosure by the recipient and may no longer be protected by the federal patient privacy laws.
- This authorization, unless I revoke it earlier, shall remain in effect for as long as my child is a student or attendee of the above-mentioned school/ day care.

Patient or Representative Signature____ Date__________________

Printed Name____ Relationship to Patient____________________