

**AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
DISCLOSURES TO SCHOOLS**

SEE THE REVERSE SIDE

Patient's Name: _____ **Date of Birth:** _____
Last First Middle

The UC Organized Health Care Arrangement (or **UC OHCA**) includes University of Chicago Hospitals, certain activities of the University of Chicago including the physicians, the UCHHS Regional Doctors Offices, and Friend Family Health Care Clinic in Hyde Park. Each is called a **UC Organization**.

PURPOSE: I authorize the UC OHCA to disclose my child's/ward's health information to his/her school during the term of this Authorization at my request. The name and address of the school is:

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes:

- Immunization information requested by the school
- Physician examination results requested by the school
- Other: _____.

TERM: This Authorization will remain in effect for one year after the date signed below.

Once the health information is disclosed to the school, neither UCH nor any UC Organization can guarantee that the school will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this authorization or applicable law governing the use and disclosure of the health information.

UC Organizations will not receive anything of value from the school because of the disclosure of the health information.

I may inspect or copy any information used/disclosed under this authorization.

I may refuse to sign this authorization and my refusal will not affect my child's/ward's ability to obtain treatment or his/her eligibility for benefits. However, if his/her treatment is for the sole purpose of creating health information that the school requires, then the UC Organization may refuse to treat him/her if I do not sign this authorization.

I understand that I may change my mind and revoke this authorization in writing at any time by notifying the Privacy Office (see the information below), and changing my mind will not affect treatment. The revocation will not apply to the extent that any UC Organization has already taken action where it relied on my permission.

I have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of the health information. I authorize each UC Organization to use or disclose my health information in the manner described above.

*Signature of Patient or Personal Representative**

Date

Name of Personal Representative (if applicable)*

Relationship to Patient

** The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.*

Privacy Office: U of C Medical Center, MC-1000, 5841 S. Maryland Avenue, Chicago, IL 60637 (773) 834-9716

Last Updated April 14, 2003

Authorization for school disclosure.doc

***Provide a copy of signed Authorization to Patient**

SPECIFIC CONSENT ATTACHMENT

If the information sought is about a Mental Illness or Developmental Disability, HIV/AIDS Testing or Treatment, Communicable Diseases, Venereal Disease(s), Substance (i.e., alcohol or drug) Abuse, Abuse of an Adult with a Disability, Sexual Assault, Child Abuse and Neglect, or Genetic Testing, then the patient must sign the Specific Consent Attachment.

Patient's Name:	_____	_____	_____
	Last	First	Middle
Date of Birth:	_____		

SPECIFIC CONSENT

By checking any of the boxes next to a category of confidential information listed below, I specifically authorize the use and/or disclosure of the category of confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- Information about a Mental Illness or Developmental Disability
- Psychotherapy Notes (which are not part of the official medical record)
- Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about Communicable Diseases
- Information about Venereal Disease(s)
- Information about Substance (i.e., alcohol or drug) Abuse
- Information about Abuse of an Adult with a Disability
- Information about Sexual Assault
- Information about Child Abuse and Neglect
- Information about Genetic Testing

I have read and understand the terms of this Attachment and I have had a chance to ask questions about the use and disclosure of the confidential information. I authorize each UC Organization to use or disclose the confidential information checked above in the manner described above.

Signature of Patient or Personal Representative

Date

Name of Personal Representative (if applicable)*

Relationship to Patient

Witness' Signature required for release of information about a mental illness or developmental disability

Signature of Witness: _____