114 West Panther Drive Bigelow Arkansas 72016 Phone: 501-759-2808 Fax: 501-759-2667

Authorization for Release of Health Information

Participant:_____

Home Address:_____

_____

_____

School: _____

I authorize the use or disclosure of the above-named individual's health information as described below:

The following individuals or organizations are authorized to make the disclosure:
(*School Business Official, Agency Representative, etc.)*

_____ _____

The type and amount of information to be used or disclosed is as follows:
(check off appropriate item(s), and include other information, where indicated)

- ☐ Name
- ☐ Other; please describe: _____
  _____

This information may be disclosed to, and used by, the following individuals or organizations: *(providers, spouse, friends, etc.)*

Name: _____ Name: _____

Address:_____ Address:_____

_____ _____

By my signature below, I authorize disclosures to and by EESD.

This information is being disclosed for the following purpose:

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the EESD Superintendent (on the header address.) I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authorization will expire at the end of the school's fiscal year.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may be protected by federal privacy regulations.

_____ _____

Signature of Participant Date

_____ _____

Superintendent of Schools Date