AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Student/Patient Name: _____
First Middle Last

Address: _____ Date of Birth: _____

Phone Number: (_____)_____ Last 4 Digits of Social Security # _____

I, the undersigned, authorize the release of health information to the Educational Service Center of Northeast Ohio. Specifically, I request that the Educational Service Center of Northeast Ohio receive pertinent **medical, audiological, psychological and/or psychiatric health information** of the Student/Patient. The purpose for the release is for school/education-related purposes, including for the Educational Service Center to assist in planning and providing support in the educational environment for the Student/Patient. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, sexually transmitted disease (STDs), HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. This authorization and consent will expire one year from the date of authorization set forth below, unless revoked by me (or my legal representative) through written notice to the doctor(s) or agencies identified below. Any revocation will not apply to information that already has been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization. I understand that, when the information is released to the Educational Service Center of Northeast Ohio, these records may no longer be protected by the HIPAA privacy regulations, and the Educational Service Center of Northeast Ohio or its designees might release the records to someone else, except as prohibited by 42 CFR Part 2, the Family Educational Rights and Privacy Act of 1974, or other applicable law.

The following doctor(s) or agencies have permission to release the above information to the Educational Service Center of Northeast Ohio.

_____ _____ _____
Service Dates Requested

_____ _____

By signing below, I affirm that I am the Student/Patient and/or the Student/Patient's personal representative, and have the authority to authorize who may access or receive health information. If this authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

_____ _____ _____
Signature Print Name Date

_____
Relationship if not Student/Patient

If someone other than the Student/Patient or Student/Patient's parent if the Student/Patient is under eighteen years of age executes this authorization, a copy of legal paperwork verifying the Student/Patient's personal representative MUST accompany the request (e.g., court appointed guardian, durable power of attorney for health care, etc.).

Scan/e-mail, fax or mail requested reports to:

Dana Lambacher
Services for Students with Hearing Loss – Essex Place
Educational Service Center of Northeast Ohio
6393 Oak Tree Blvd.
Independence, OH 44131
Fax: (216) 524-3683
E-mail: dana.lambacher@escneo.org