LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ DOB: _____

SSN: _____

1. The undersigned, the patient or parent/guardian of the above named patient, authorizes the HEALTH CARE PROVIDER to make the disclosure of the PATIENT'S health information as described below. This authorization is intended to comply with requirements of the Health Insurance Portability and Accountability Act of 1996(HIPPA), HIPPA regulations, and other State and Federal laws and regulations that may create a right of privacy in the health information approved to be disclosed by this authorization.

2. The health information to be disclosed is as follows(dates are included if a limitation to date applies):
   All medical records relating to PATIENT'S health that are in HEALTH CARE PROVIDER'S possession from July 1 2021 to June 30 2022.

3. This information may be disclosed to and used by the following individual or Organization:
   Jonesboro School District (all schools within its jurisdiction).

4. The purpose or use of the disclosure is as follows:
   At the request of the patient or parent/guardian_____

   Other: To verify doctor's visits and treatment, which are used for excuses for absences from school.

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the HEALTH CARE PROVIDER. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: one (1) year from date of execution. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and Treatment for alcohol and drug abuse. I further understand that authorizing the Disclosure of this health information is voluntary. I can refuse to sign this Authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed.