



Academy of Arts and Knowledge

Creating an environment in which all students can reach their full potential

4800 Wheaton Drive, Fort Collins, CO 80525 Phone (970) 226-2800

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____

- I. **THE PATIENT.** This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name:	
Date of Birth:	

- II. **AUTHORIZATION.** I authorize _____ ("Authorized Party") to use or disclose the following: (check one)

III.

<input type="checkbox"/>	All of my medical related information.
<input type="checkbox"/>	My medical information ONLY related to: _____
<input type="checkbox"/>	My medical related information from: _____ thru _____
<input type="checkbox"/>	Other: _____

Hereinafter known as the "Medical Records." DISCLOSURE.

- IV. **DISCLOSURE:** The Authorized Party has my authorization to disclose Medical Records to: (check one)

V.

To:	The Academy of Arts & Knowledge	In C/O:	Carrie Martin, BSN-RN
Address:	4800 Wheaton Drive, Fort Collins, CO 80525		
Phone:	970-226-2800	E-mail:	cmartin@aakelementary.org

- VI. **PURPOSE.** The reason for this authorization is for general purposes related to patient's attendance and participation in school.

- VII. **TERMINATION.** This authorization will terminate:

At the end of the current school year:	
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- VIII. **ACKNOWLEDGMENT OF RIGHTS.** I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.



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I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient:		Date:	
Print Name:			
<i>(If patient is unable to sign, use the signature area below)</i>			

The patient is unable to sign due to: (check one)

<input type="checkbox"/>	Minor. Patient is		years old and considered a minor under state law.
<input type="checkbox"/>	Incapacitated. Patient is incapacitated due to:		
<input type="checkbox"/>	Other:		

Signature of Representative:		Date:	
Print Name:			
Relationship to Patient:	<input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian		
	Other:		