

**Aberdeen School District No. 58  
HIPAA Authorization Form  
for the Release of Protected Health Information (PHI)**

At my request, I authorize Aberdeen School District No. 58 (hereinafter "School District") to disclose protected health information (PHI) as described below.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Person or Organization Receiving the Information:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Description of specific information to be disclosed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The date or event when this authorization expires: \_\_\_\_\_

(If not specified, this authorization will expire one year from the date of signature.)

I understand that if the person or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations, the person or organization may not be obligated by state or federal law to protect it.

I understand that I may cancel this authorization in writing at any time by sending a written request to the School District offices. My cancellation of this authorization will not affect any action the School District took prior to receiving my cancellation request.

This authorization is voluntary. The School District will not condition my enrollment in the health plan or eligibility for payment of benefits on receiving this authorization.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
(If signed by a personal representative of the employee, please complete the following.)

Personal Representative's name: \_\_\_\_\_

Relationship to Employee: \_\_\_\_\_  
(i.e., parent, legal guardian, holder of power of attorney. Please attach legal documentation of relationship other than parent.)