InterCommunity, Inc.

HIPAA Authorization to Use and Disclose Information

Please note that this is a legal document and will not be honored unless it is completed in full.

Student Name:	SSN:	DOB:
School:	Grade:	

I hereby authorize **InterCommunity, Inc.** and its representatives ("**InterCommunity**") to **disclose** the information described below to be **used for the purpose of** working with the East Hartford School District and its staff at my child's school (including, but not limited to, school nurses) to manage and coordinate my child's health care and educational needs. For purposes of this Authorization, if the student is eighteen years or older, or otherwise permitted by law to sign this form for him or herself, all references in this document to "my child" will be taken to refer to the individual student.

DISCLOSURE PERMITTED TO: Disclosure may be made to the East Hartford School District and its staff at my child's school (including, but not limited to, school nurses).

INFORMATION TO BE DISCLOSED: The information to be disclosed includes all protected health information that InterCommunity determines to be necessary or appropriate to share for the purpose of managing and coordinating my child's care and educational needs; provided that delivery of copies of my child's written medical records or psychotherapy notes, if any, is not permitted and will require a separate Authorization form to be executed. Stated plainly, InterCommunity may disclose information orally as described above, but will seek further permission to deliver any written records.

The following information shall be included only if checked: (check the appropriate boxes)

- ☐ Substance abuse information
- ☐ Mental health information
- ☐ HIV-related information

DATE, EVENT, OR CONDITION WHEN THIS AUTHORIZATION IS TO EXPIRE: This Authorization shall remain in effect as long as my child is enrolled in the East Hartford School District and InterCommunity, Inc. is operating the School Based Health Center, unless revoked sooner as provided at the bottom of this form.

DATES OF TREATMENT COVERED BY THIS AUTHORIZATION: This authorization covers all dates of service and authorizes the ongoing exchange of information. This exchange will expire upon revocation of this Authorization or as otherwise provided above for termination.

I understand that refusal to grant permission will in no way affect my child's right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I understand that I may revoke this authorization at any time when I sign the "Cancellation" section of this Authorization, unless action has been taken in reliance on this authorization. I understand the reasonable benefits and disadvantages of my decision concerning disclosure of the information specified above.

I understand that the information used or disclosed by this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws; provided that if I am authorizing the disclosure of HIV-related, mental health, or substance abuse treatment information, the recipient is prohibited from further disclosing such information without my specific written consent unless otherwise permitted under federal or state law.

Personal Representative/Student Signature	Date

Description of Personal Representative authority (*e.g.*, parent) _____

Cancellation of Authorization:

Personal Representative/Student Signature	*Date*

Revised: 6/1/2017