HS0015
Rev. 3/19

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Health Services Department
Lincoln Public Schools
Phone: 436-1655

PART I Identification

Student's Name _____ Date of Birth _____

Disclosing Party _____ School: _____

(Name of Hospital, Clinic, or Doctor to Release Records)

Address: _____ City:_____ State: _____ Zip:_____

PART II Authorization for Release of Health Information

I hereby authorize the Disclosing Party and its employees and agents to exchange health information about the Student with LPS.

1. YOU ARE AUTHORIZED TO EXCHANGE THE FOLLOWING HEALTH INFORMATION:
   - ☐ All health information about Student and any information requested by LPS
   - ☐ Any and all information for a school physical
   - ☐ Any and all information about a particular admission, treatment or episode of care
     Specify: _____
   - ☐ The following health information: _____
     _____
2. DOES THIS AUTHORIZATION INCLUDE:
   - ☐ Yes ☐ No Alcohol/drug abuse information of part of the specified record
   - ☐ Yes ☐ No Mental health information if part of the specified record
   - ☐ Yes ☐ No HIV/AIDS-related information (including test results) if part of the specified record
   - ☐ Yes ☐ No Genetic testing information if part of the specified record

   (Note: This authorization does NOT include authorization for psychotherapy notes even if part of the specified record. A separate authorization will be provided if necessary for disclosure of psychotherapy notes.)
3. WHAT OTHER LIMITATIONS APPLY? If none, write "none." _____
4. PURPOSE: What is the purpose of the disclosure? (Note – If the disclosure is at the patient's request, simply state "at the patient's request."): _____
5. THIS AUTHORIZATION IS VALID UNTIL: _____
   (Note: Unless otherwise stated, I request that this authorization be considered as valid for 12 months from date of signature)

Additional Important Terms Which I have been notified of:

1. **Not a Condition for Treatment.** Refusal to sign this authorization will not affect my ability to receive treatment from the Disclosing Party.
2. **Further uses and Disclosures.** Health information to be disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by State or Federal privacy laws.
3. **Right to Revoke.** I may revoke this authorization at any time by giving written notice to the Disclosing Party. My revocation will not be effective to the extent action has already been taken in reliance on your authorization prior to receipt of my written revocation.
4. **Photocopies.** A photocopy or exact reproduction of this signed authorization will have the same force and effect as the original.
5. **Keep a Copy.** By signing below, I acknowledge receipt of a copy of this Authorization.

PART III Send Records to LPS at:

Name _____

Fax Number _____

Address_____ Lincoln, NE 685 ___

For Questions Contact: **Lincoln Public Schools, Department of Student Services**
5905 O Street, Lincoln, NE 68510
Phone: (402) 436-1688 Fax: (402) 436-1686

_____ _____
Signature of Parent (or Student if of Age of Majority) Date

_____
Contact Information (Address & Phone)