Authorization for REQUEST of Health Care Information - Please read entire document before signing.

This authorization gives the Milton Hershey School permission to request and/or use health information about your child.

1. I authorize _________________________________ to disclose the following information from the health records of:

Patient's Name: ______________________________ Date of Birth: ______________

2. Covered health information **(See below for records marked with an *)**

☐ Medical Records	☐ Immunization Records	☐ Medications
☐ Dental Records	☐ Orthodontic Records	☐ Social Work Records
☐ **Psychiatric Evaluations***	☐ **Psychological Evaluations***	☐ **Psychological History***
☐ Verbal Exchanges	☐ Discharge Summaries	☐ Summary of Treatment to Date
☐ Educational Records	☐ Other ______________________	

I understand this will include the following information indicated and initialed below:

☐ Initialed _______ **AIDS or HIV infection****	☐ Initialed _______ **Behavioral Healthcare***
☐ Initialed _______ **Treatment for alcohol or drug abuse***	☐ Initialed _______ **STDs or Other Reportable Diseases***
☐ Initialed _______ **Reproductive healthcare records***	

*Patients must specifically authorize disclosure of AIDS/HIV status, STDs or other reportable disease infections, treatment for drug or alcohol abuse, and reproductive healthcare records. Patients 14 years of age or older must authorize disclosure of psychiatric, behavioral healthcare, and psychological records.

**This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

***Even if the patient specifically authorizes disclosure of treatment for drug or alcohol abuse records, those records may only be disclosed to medical personnel for the exclusive purpose of diagnosis and treatment or Government or other officials for the exclusive purposes of obtaining benefits for the patient as a result of alcohol or drug abuse or dependence.

3. This information is to be disclosed to:

Jennifer Wallace, MD
Milton Hershey School – Health Center
P. O. Box 830
Hershey, PA 17033-0830

Fax: (717) 520-2046
Phone: (717) 520-2379

4. Purpose of authorization:
   - ☐ To assist the Milton Hershey School in providing comprehensive health care for the patient.
   - ☐ To facilitate continuity of care
   - ☐ At request of outside healthcare providers.
   - ☐ Other ______________________________

5. Expiration of authorization: Termination of enrollment or graduation from the Milton Hershey School.
   - ☐ One year from signature ______________________________

6. You may revoke this authorization at any time, except to the extent that we have relied on the authorization, by submitting a written revocation to the Milton Hershey School at the following address:

Beth Shaw, Ph.D.
Executive Director, Student Support Services
Milton Hershey School
P.O. Box 830
Hershey, PA 17033-0830

Fax: (717) 520-2068
Phone: (717) 520-3069

Revoking this authorization may affect your child's enrollment at the Milton Hershey School.

Re-disclosure: Health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by the federal privacy rules relating to healthcare provider records. See, however, ** above in regard to AIDS or HIV infection information.

I have read and understand this authorization, and authorize use and disclosure of health information about the named patient as described in this authorization.

Name of Personal Representative and Relationship to Patient:

______________________________ ______________________________

*Signature of Patient (or Personal Representative)

Date: ____________________

Revised: 10/1/12