Authorization for Request of Health Care Information

Please read entire two-page 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

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 _____**Reproductive healthcare records***
☐	Initialed _____**STDs or Other Reportable Diseases***		

*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, or psychological records. **If records for treatment of drug or alcohol abuse are being requested, a separate specific Authorization is required for that purpose.**

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.

I understand that the covered entity seeking authorization may not consider this Authorization or my refusal to sign this Authorization a condition of treatment, payment, enrollment in the health plan or eligibility for benefits.

3. This information is to be disclosed to:

Lead Physician
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 the 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:

Managing Director, Student Health 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.

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

Signature of Patient (or Personal Representative)	Print Name of Personal Representative and Relationship to Patient	Date
Signature of Student (14-17 years old)	Print Name of Student	Date
Signature of Witness	Print Name of Witness	Date

I have been offered a copy of this document and I have: _____ Accepted _____ Refused