

**Authorization for Release of Health Care Information**  
**Please read entire two-page document before signing**

This Authorization gives the Milton Hershey School permission to use and/or disclose health information about a student.

1. I authorize the Milton Hershey School 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 \*)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Medical Records                 | <input type="checkbox"/> Immunization Records              | <input type="checkbox"/> Medications                   |
| <input type="checkbox"/> Dental Records                  | <input type="checkbox"/> Orthodontic Records               | <input type="checkbox"/> Social Work Records           |
| <input type="checkbox"/> <b>Psychiatric Evaluations*</b> | <input type="checkbox"/> <b>Psychological Evaluations*</b> | <input type="checkbox"/> <b>Psychological History*</b> |
| <input type="checkbox"/> Verbal Exchanges                | <input type="checkbox"/> Discharge Summaries               | <input type="checkbox"/> Summary of Treatment to Date  |
| <input type="checkbox"/> Educational Records             |  |  |

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

- |  |  |
|--|--|
| <input type="checkbox"/> Initialed _____ <b>AIDS or HIV infection*</b>               | <input type="checkbox"/> Initialed _____ <b>Behavioral healthcare*</b>           |
| <input type="checkbox"/> Initialed _____ <b>Treatment for alcohol or drug abuse*</b> | <input type="checkbox"/> Initialed _____ <b>Reproductive healthcare records*</b> |
| <input type="checkbox"/> Initialed _____ <b>STDs or Other Reportable Diseases*</b>   |  |

\* 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. **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:

Name	_____	Name	_____
Address	_____	Address	_____
City	_____	City	_____
State	_____	State	_____
Zip code	_____	Zip code	_____
Phone Number	_____	Phone Number	_____
Fax Number	_____	Fax Number	_____
Email	_____	Email	_____

**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:**

- Current Students: Termination of enrollment or graduation from the Milton Hershey School
- Alumni: 1 year from the date on this request
- One year from signature
- Other \_\_\_\_\_

**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:**

Senior Director, Student Health Services                      Fax: (717) 520-2068  
Milton Hershey School    Phone: (717) 520-3069  
P.O. Box 830  
Hershey, PA 17033-0830

**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