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 (*)

☐ 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 _____ **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, 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: _____
_____

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:

☐ 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:

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 the student's enrollment at the Milton Hershey School.

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

_____ _____
Signature of Patient (or Personal Representative) Name of Personal Representative and Relationship to Patient

_____ _____
Signature of Witness Date

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