FORM B: HIPAA AUTHORIZATION

AUTHORIZATION FORM
Student Authorization for Use and Disclosure of Protected Health Information

Student Name: _____("Student") Date of Birth: _____

By signing this form, I hereby authorize Aultman Orrville Hospital and Aultman designated affiliates ("Aultman Orrville") to disclose health information about Student to any employee of the Claymont City School District ("Claymont") and to Student's parents/authorized representatives for treatment, payment, or healthcare operations. I understand that any health information disclosed by Aultman Orrville to Claymont pursuant to this Authorization may be incorporated into Student's education records and may be accessed by others who are legally permitted to view such records.

This authorization permits Aultman Orrville to use and/or disclose protected health information about Student, including, without limitation, all notes of physicians, nurses, psychologists, counselors. and other persons who have provided or who are providing health care to the undersigned individual, all radiology and pathology records, and other sensitive information (including HIV/STD information, genetic testing information, mental health information, and alcohol and drug abuse information).Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act ("'HIPAA'").

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Aultman Orrville Hospital, ATTN: Medical Records Department, 832 South Main Street, Orrville, OH 44667. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization. Aultman Orrville will not condition my treatment or payment for my treatment on whether I provide authorization for the requested use or disclosure. I also understand I have the right to a copy of this Authorization.

I understand that information used or disclosed pursuant to this Authorization may be used or disclosed by the recipient and may no longer be protected by federal or state law.

I have read this form or have had it read to me. I understand what it says.

Student Signature: _____ Date: _____
(If Student is Over Age 18)

Parent/Legal Guardian* Signature: _____ Date: _____
(If Student is Under Age 18)

*If signed by a Legally Authorized Representative, provide your name and describe your authority to act for the individual below (e.g., parent, legal guardian, healthcare power of attorney, etc.).