Flagstaff Unified School District #1 Authorization Form for Release of Protected Health Information (PHI)

I, ______, hereby authorize the use or disclosure of the health

information as described in this authorization.

1. Specific person/organization/or class of persons authorized to **provide** the information:

- 2. Specific person/organization/or class of persons authorized to **receive** and use the information (*insert name, title, address fax, phone and e-mail if possible*):
- 3. Specific **description of the information to be used or disclosed** (*Include names of individuals to whom the information pertains such as a minor child, description of information and dates, as appropriate*):
- 4. **Purpose of the request** (*Check one*): \Box At the request of the individual signing this form.

 \Box Other: ____

- 5. **Right to Revoke:** I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the Privacy Officer (in writing) at the address noted below. I understand that such a revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.
- 6. I understand that after this information is disclosed, Federal law might not protect it and the recipient might disclose it again.
- 7. I understand that I am entitled to receive a copy of this authorization and the information described on this form if I ask for it.
- 8. I understand that this authorization will expire as indicated here: □ One year from the date of this authorization. □ On the following date: ______, 20____.
- 9. The Plan will not condition treatment, payment, enrollment or eligibility for benefits on receipt of an authorization.
- 10. If this authorization is **for marketing purposes**, this Plan is not receiving financial remuneration (payment) from the third party whose service or item is being marketed. If the authorization is **for the sale of Protected Health Information**, the disclosure will not result in remuneration (payment) to the Plan.

Signature of Individual	or	Date		
Signature of Personal Representative		Date		
If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of: \Box a signed Personal Representative Form; or \Box Other				
Acknowledgement by the Privacy Officer:			Date:	, 20

This authorization reflects the requirements of 45 C.F.R. § 164.508 (8-14-02) and updated for HIPAA Omnibus (9-23-13).

Once completed, please return this form to the: Privacy Officer for Flagstaff Unified School District #1 3285 E. Sparrow Ave., Flagstaff, AZ 86004 Phone: 928/527-6046 Confidential fax #: 928/527-6065

Flagstaff Unified School District #1

Form to Revoke/Terminate a Prior Authorization

I, _	, hereby revoke/terminate an authorization that I made on			
	, 20 regarding the use or disclosure of my health information.			
1.	Specific person/organization/or class of persons who was authorized to provide the information:			
2.	Specific person/organization/or class of persons who was authorized to receive and use the information:			
3.	Specific description of the information that was allowed to be used or disclosed.			
	(Include dates as appropriate):			
4.	I understand that the revocation/termination is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the date of this revocation/termination will not be affected by this revocation/termination request.			
	Signature of Individual Date or Or			
	Signature of Personal Representative Date			
	Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization m on the basis of:			
	A signed Personal Representative Form;			
	Other:			
_				
Ac	knowledgement by the Privacy Officer: Date:, 20			
	Once completed, please return this form to the: Privacy Officer for Flagstaff Unified School District #1 3285 E. Sparrow Ave., Flagstaff, AZ 86004 Phone: 928/527-6046 Confidential fax #: 928/527-6065			

Flagstaff Unified School District #1 Form to Appoint a Personal Representative

Complete the following chart to indicate the name of the proposed Personal Representative

	Plan Participant:	Proposed Personal Representative:
Name (print):		
Address (City, State, Zip):		
Phone:	()	()
IMPORTANT: Insert the Personal Representative's Password for Telephonic Identification:		

I,	 [Name	of	Participant	or	Beneficiary]	hereby	designate
]	Nam	e of Personal K	Represente	ative]:

 \Box to act on my behalf,

□ to act on behalf of my dependent child(ren) named:

in receiving:

- a. any Protected Health Information (PHI) that is (or would be) provided to me as a participant/beneficiary of the Plan, including any individual rights that I have regarding my PHI under HIPAA.
- b. only the following Protected Health Information to conduct the following functions on my behalf:

I understand that this designation of a Personal Representative is subject to approval by the Plan. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by completing a form to Revoke a Personal Representative available from the Privacy Officer. I understand that I may review a copy of the Plan's Policy on Personal Representatives.

Participant or Beneficiary's Signature	Date			
Personal Representative's Signature	Date			
The above Personal Representative request is:				
□ approved.				
11				
□ not approved because:				
••		, 20		

Flagstaff Unified School District #1 Form to Revoke a Personal Representative

Complete the following chart to indicate the name of the Personal Representative to be revoked:

	Plan Participant:	Person to be Revoked as my Personal Representative:
Name (print):		
Address (<i>City</i> , <i>State</i> , <i>Zip</i>):		
Phone:	()	()

I,	(Name of Participant or Beneficiary)
hereby revoke the authority of	(Name of Personal
<i>Representative</i>)	

 \Box to act on my behalf,

to act on behalf of my dependent child(ren), named:

in receiving any Protected Health Information (PHI) that is (or would be) provided to a personal representative, including any individual rights regarding PHI under HIPAA, effective ______ 20____.

I understand that PHI has or may already have been disclosed to the above named Personal Representative prior to the effective date of this form.

Participant or Beneficiary's Signature

Date

Acknowledgement by the Privacy Officer: _____ Date: _____, 20____

Once completed, please return this form to the: Privacy Officer for Flagstaff Unified School District #1 3285 E. Sparrow Ave., Flagstaff, AZ 86004 Phone: 928/527-6046 Confidential fax #: 928/527-6065