MED CENTER HEALTH

Connie D. Smith
CHIEF EXECUTIVE OFFICER

MEDICAL INFORMATION RELEASE AUTHORIZATION

I, _____ (Parent/Guardian Name), give authorization for the **Barren River District Health Department**, 1109 State Street, Bowling Green, KY 42101 to release information from the Logan County Schools student health file on:

Student Name: _____ Date of Birth: _____

Social Security Number: _____ School Attending: _____

To release the following records to **Med Center Health**, 1020 South Main Street, Franklin, KY 42104:

- Medication Administration Record 2019-2020 school year
- Controlled Substance/Uncontrolled Substance Logs 2019-2020 school year
- Physician Orders 2019-2020 school year
- Authorization Forms 2019-2020 school year
- Hearing and Vision Screenings each year performed
- Immunization Record (current)
- Health Questionnaire 2019-2020 school year
- Nurse Notes for 2019-2020 school year
- Nurse Visits for 2019-2020 school year
- Permission form for prescribed medication 2019-2020 school year

The reason for the release is due to Med Center Health will replace Barren River District Health Department in providing nurses for the school health program at Logan County Schools beginning January 1, 2019.

I understand that this authorization is valid only for a maximum of 180 days from the date below, and it covers only treatment prior to December 19, 2019.

This information may be released by facsimile machine if request warrants. Med Center Health and its subsidiaries are hereby released from any liability and the undersigned will hold Med Center Health harmless for complying with this authorization. A Photostat copy of this authorization is acceptable and will be treated as original.

The undersigned acknowledges that the provision of free medical records by any healthcare provider who receives this release shall fulfill that healthcare provider's obligation to provide one free copy of the medical records, and that any future report request for medical records from the healthcare provider may result in a copying fee up to one dollar per page.

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I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Revocation date: _____ Patient/Legal Representative: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information comes with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

X Parent/Legal Representative Signature: _____ Date: _____

XRelationship to Student: _____

Please mail or fax the completed authorization form to:

Med Center Health
1020 South Main Street
Franklin, KY 42134
Fax: 270-586-0255