WASHINGTON COUNTY HEALTH DEPARTMENT

SCHOOL BASED WELLNESS PROGRAM

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

for treatment, payment and health care operations

When you sign this form, you understand that School Based Wellness Center may obtain/release your child's health information. This information would be for purpose of treatment, payment and health care operations.

We have given you a copy of our **Notice of Privacy Practices**. It provides more detailed information about how we may use and release your child's protected health information. We encourage you to read it in full. Your signature on this form acknowledges that you have been given a copy of the **Notice of Privacy Practice**.

This agreement/release of information will remain in effect until cancelled in writing by parent/guardian. This would not include information we had already used or released prior to the cancellation.

	Please Initial
I give Washington County School Based Wellness Center staff permission to call my contact numbers with health care information.	___________
I give Washington County School Based Wellness Center staff permission to leave a message with health care information on an answering machine or with a person at my home.	___________
I give Washington County School Based Wellness Center staff permission to mail health care information to my house.	___________
I request to receive communications from Washington County School Based Wellness Center as follows:	
____	___________

Child's Printed Name: ___________________________________ Date of Birth: _____/_____/_____

PARENT/GUARDIAN SIGNATURE: _____________________________ Date: _________________

WCHD SBWC 03 6/06; 6/08; 6/09