AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO SCHOOL

Patient/Student Name:

Name of Patient / Previous Names

Birth Date (MM/DD/YYYY)

Street Address

City, State, Zip Code

To be Requested from:

MILLWOOD HOSPITAL
1011 N. COOPER ST, ARLINGTON, TX 76011
Phone: (817) 261-3121
Email: Millwoodroi@uhsinc.com

To Release to:

School Name:

Street'Address'

City,State, Zip Code

School Contact:

Fax Number/Email:

Format to be provided: _____ Printed Copy _____Electronic Copy

Dates of Service: _____to_____

Only the information and records indicated below (select all that apply):

☐ Safety/Crisis Plan

☐ Return to School Plan

☐ Aftercare Plan

☐ Verbal Communication – Regarding patient progress only

☐ No Contact at All --*By selecting this option, I, as the legal guardian, acknowledge and accept full responsibility for all communication and disclosure of Protected Health Information (PHI).*

Purpose of Disclosure:

☐ Development of IEP/504 Plan
☐ Behavior Support Plan
☐ Other: _____

I understand that if the person(s) or organization(s) listed above are not health care providers, health plans, or health care clearinghouses that are required to follow federal privacy standards, the health information disclosed under this authorization may no longer be protected by those standards and could potentially be re-disclosed without my further authorization.

This authorization is intended to allow MILLWOOD HOSPITAL to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

Expiration Date: This authorization remains valid until the following date(s): _____or for one year from the date signed,
I have had the opportunity to review and understand the contents of this authorization form. By signing below, I confirm that this authorization accurately reflects my wishes.

Signature of Patient or Guardian:_____ Date: _____

If signed by someone other than the patient, please indicate your legal authority and attach supporting documentation:
☐ Parent or Legal Guardian of a Minor
☐ Holder of Power of Attorney
☐ Other: _____

Staff Signature:_____

Rev. 08/07/2025