AUTHORIZATION FOR RELEASE OF RECORDS

Name_______________________________________DOB:______________________

This authorization is written permission for Gouverneur Central School to disclose my protected health information as directed below:

I, ____________________________________, hereby authorize Gouverneur Central
name

School to disclose my protected health information to:

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The specific information to be disclosed includes:

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The protected health information will be disclosed for the following purposes:

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The authorization will expire in thirty (30) days or will be in effect until _____________.
date

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notice to Gouverneur Central School.

I understand that the revocation is only effective after it is received and recorded by GCS and is not effective to the extent that GCS has already relied upon the authorization.

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

I understand that I have the right to inspect or copy the protected health information to be disclosed as permitted by federal law (or state law to the extent the state law provides greater access rights)

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Signature of Person or Personal Representative Date