WI
West Islip Public Schools

Health Services Authorization Form (HIPAA)
Authorization for Disclosure of Protected Health Information

1. I authorize the following healthcare practitioner to disclose my protected health information, as specified below.

Name and address of applicant's practitioner	*Name and address of district's practitioner*

2. I hereby authorize the disclosure of the following protected health information:

Specifically describe the protected health information to be disclosed such as date(s) of service, type of service and level of detail to be released.

2. This protected health information is being used or disclosed in support of the employee's Incapacitating Illness or Accident Application.

4. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.

7. The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if healthcare services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Print Name of Patient {Employee}		Date	
Signature of Patient {Employee}			