SPRING RIDGE ACADEMY
13690 S. Burton Rd. – Spring Valley, AZ 86333
Office: (928) 632-4602 – Fax: (928) 632-7661

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

(*Reproduce this form as needed*)

Spring Ridge Academy (SRA) is authorized to use/disclose information as noted below about:

STUDENT NAME: _____ Date of Birth: _____

To/From the following person/organization:

NAME: _____ TITLE: _____

ADDRESS: _____

PHONE: _____ FAX: _____

- ☐ Admission and discharge summaries
- ☐ Psychological and/or Psychiatric evaluation(s), reports, testing, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations
- ☐ Treatment, aftercare plans and other similar plans
- ☐ Social, family, education, and vocational histories
- ☐ Verbal progress reports, observations and recommendations
- ☐ Information about how patient's condition(s) affects or has affected her ability to participate in school and to complete tasks or activities of daily living
- ☐ Academic & educational records, including achievement & other tests' results, reports of teachers' observations, and all other school or special education documents
- ☐ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: ☐ Do not release these
- ☐ Other _____

Dates of care included: From _____ to _____ and
From _____ to _____

The information will be used/disclosed for the following purposes:

_____

_____

- I understand and agree that this Authorization will be valid and in effect until: _____
  I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
- I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Spring Ridge Academy.
- I understand that I may inspect and have a copy of the health information described in this authorization.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I understand that this professional will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.
- I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Signatures: _____ _____
Father/Guardian Signature Date Mother/Guardian Signature Date

I, an authorized representative from SRA, have discussed the issues above with the client and/or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature & Printed Name of Authorized SRA Representative Date