



SOUTH EASTERN SPECIAL EDUCATION

Serving Clay, Crawford, Jasper, Lawrence, and Richland Counties

JILL KELLER - WEEMS, DIRECTOR

AUTHORIZATION FOR USE AND DISCLOSURE TO SOUTH EASTERN SPECIAL EDUCATION OF MEDICAL INFORMATION

Section A: Must be completed for all authorizations.

I hereby authorize the use or disclosure of individually identifiable health information as described below. I understand that this authorization is voluntary.

Student/Patient Name

Medical Provider's
Patient ID Number (if known)

Persons/Organizations authorized to release the information:

Persons/Organizations authorized to receive the information:

South Eastern Special Education and _____
(If specific individuals)

Specific description of information (including date(s)):

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire 365 days after it is made.
Initials: _____

2. I understand that I may revoke this authorization at any time by notifying South Eastern Special Education in writing, but, if I do revoke this authorization, my revocation will not have an effect on any actions South Eastern Special Education took in reliance upon my authorization before it received my revocation.
Initials: _____

P.O. BOX 185 ■ STE. MARIE, IL 62459 ■ 618-455-3396 ■ FAX 618-455-3134

South Eastern Special Education does not discriminate on the basis of race, color, religion, sex, age, handicap or national origin in the provision of educational services or in the participation in educational services as required by federal and state laws.

You may revoke this authorization by signing a Revocation of Authorization form and returning it to South Eastern Special Education. To request a Revocation of Authorization form, you may contact South Eastern Special Education

Name, Address, Telephone Number of SESE Contact Person.

Section B: Must be completed by South Eastern Special Education when South Eastern Special Education requests information

1. The purpose of the use or disclosure is:

2. South Eastern Special Education will will not receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: You or your representative may inspect and/or copy the health information in accordance with South Eastern Special Education's policies.

Section C: Must be completed for all authorizations.

Patient Name: (Please Type or Print) Patient Social Security Number: _____

Signature of patient (18 or older) or patient's representative Date _____

Printed name of patient's representative: _____
Relationship to patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
However failure to authorize release of information may result in the following:

