SOUTH EASTERN SPECIAL EDUCATION
Building Brighter Tomorrows
Serving Clay, Crawford, Jasper, Lawrence, and Richland Counties
Kim Kessler, 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

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

The purpose of the use or disclosure is:

_____

_____

_____

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)

_____ _____

Signature of Patient (if 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:

_____

_____