AUTHORIZATION TO RELEASE HEALTH-CARE INFORMATION

1) I hereby authorize:

Name of sending person/organization: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____ Fax number: _____

2) To disclose to:

Recipient name: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____ Fax number: _____

3) Records and information pertaining to:

Applicant/Student Name:		**Date of Birth:**	
Previous Name:		**Medical Record # (if known):**	

4) Purpose of request: ☐ Job Corps Program Enrollment ☐ Continuity of Care ☐ Other: _____

5) This request and authorization applies to:

☐ Health-care information relating to the following treatment, condition, or dates: _____

_____

☐ Hospitalization Records (from _____ to _____)

☐ Emergency Department Records (from _____ to _____)

☐ Immunization Records

☐ Laboratory Results (date): _____ Name or type of test: _____

☐ Radiology Images (exams/dates) _____

☐ Drug/Alcohol Records (from _____ to _____) Signature _____

☐ Mental Health/Psychiatric Records (from _____ to _____) Signature _____

☐ HIV/AIDS Records (from _____ to _____) Signature _____

☐ Genetic Testing Records (from _____ to _____) Signature _____

_____

Applicant/Student Signature **Date**

_____

Signature of Parent or Guardian (if applicant/student is an unemancipated minor) **Date**

I understand that I may revoke this authorization in writing submitted at any time to the Job Corps Outreach and Admissions Contractor or Center except to the extent that action has been taken in reliance on this authorization. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

THIS AUTHORIZATION EXPIRES I YEAR AFTER THE DATE OF SIGNATURE.

AUTHORIZATION TO RELEASE
HEALTH-CARE INFORMATION INSTRUCTIONS

Purpose:

Admissions Counselors (AC) or centers may use the "Authorization to Release Health-care Information" to obtain medical, mental health, substance use, and dental records of Job Corps applicants/students. Additionally, centers may have students complete this form to authorize release of information from the student health record to an outside healthcare provider in case of medical separation or for continuity of care.

Some health-care providers will only release information using their specific form. In that case, students should request that form from the provider.

Instructions:

1) Print the name and contact information of the person/organization that is sending the health-care information.
   - If Job Corps is using this form to request records from an outside healthcare provider, the hospital, organization, agency, or provider that is being asked to release copies of the records should be entered in this section.
   - If Job Corps is releasing all or part of the student health record to another provider, the Job Corps center's information should be entered in this section.

2) Print the name and contact information of organization that is to receive the copies of the health-care information.
   - If Job Corps is asking for medical records to be sent from an outside health-care provider, the Outreach and Admissions office or the center information should be entered in this section.
   - If Job Corps is releasing health-care information, the contact information for the entity to which the center is releasing information should be entered in this section.

3) Print the name of applicant/student (including the middle name), birth date, any previous name (e.g., maiden name or change of name), and medical record/ID # (if known).

4) Check the reason for releasing the information.

5) Check all boxes that apply. If none of the boxes apply, write in the information requested in the area that states, "Health-care information relating to the following treatment, condition, or dates." To release information that applies to drug/alcohol records, mental health/psychiatric records, HIV/AIDS, or genetic testing, an additional signature is required. In some states, unemancipated minors must release their own specially protected health information; in other states, a parent must sign to release this information. See: http://www.ndaa.org/pdf/Minor%20Consent%20to%20Medical%20Treatment%20(2).pdf for state-by-state guidance.

Signature: Applicant/student and parent/guardian (if applicant is unemancipated minor) must sign and date the form.

The person who assists the student in completing this form should ensure that applicant/student or applicant's/student's parent or guardian understands the release is valid for 1 year from the date of signing and may be revoked in writing at any time.