DukeHealth

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Place Patient Label Here

## AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you.
**THIS FORM MUST BE COMPLETED IN FULL**

Name of Patient: _____ Room Number: _____

Patient's Age: _____ Patient's Grade Level: _____ Patient's School: _____

I AUTHORIZE STAFF AT **DUKE UNIVERSITY HOSPITAL**
to disclose the following information contained in the medical records specified above to:
DURHAM PUBLIC SCHOOLS-HOSPITAL SCHOOL/HOMEBOUND SERVICES
Duke South Box 3039, Durham, NC 27710 Phone #919-684-5684

### INFORMATION TO BE DISCLOSED:

- Parent(s) name or legal representative
- Parent(s) or legal representative contact information (phone numbers, address, and hospital room number)

**PURPOSE:** The purpose and limitations of the requested use or disclosure is to provide information about the DURHAM PUBLIC SCHOOLS-HOSPITAL SCHOOL/HOMEBOUND SERVICES program, available for patients ages 3 years and up at Duke University Hospital, regardless of previous school experience. And, to authorize the teacher to visit the patient at the hospital and to contact patient's parent or legal representative.

**EXPIRATION**: This authorization will automatically expire one (1) year from the date of execution.

**REMUNERATION**: I understand that Duke University Hospital WILL NOT receive remuneration (payment) from any third party, including Durham Public Schools, for the use and/or disclosure of my information.

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## MY RIGHTS:

- I understand authorizing the disclosure of information identified above is voluntary.
- I may refuse to sign this authorization. My refusal WILL NOT affect my ability to obtain treatment or eligibility for benefits. If I refuse, hospital staff will not disclose my information to Durham Public Schools representatives and Durham Public Schools Representatives WILL NOT visit me at the hospital.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

At Duke University Hospital:
Duke University Hospital Attn: Child Life Specialist
2301 Erwin Road, Durham, NC 27710
#919-681-5419

- I have a right to receive a copy of this authorization.

Signature of Parent/Legal Representative:_____ Date: _____ Time: _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Healthcare Power of Attorney ☐ Next of Kin ☐ Spouse

☐ Other (relationship: _____)

**OR**

Signature of Patient (18 yrs or older): _____ Date: _____ Time: _____

Name/Title of Person Obtaining Consent: _____ Date: _____ Time: _____

(Attending physician or appropriately credentialed designee)

**Interpreter services offered/utilized (select one):**

☐ No interpreter needed (no language barrier)
☐ Facility provider/staff used (approved bilingual provider/staff member
☐ Facility-provided interpreter (via video)
☐ Facility-provided interpreter (via telephone)
☐ Facility-provided interpreter (in person)
☐ Refused – Language Waiver Obtained (>18 y/o Family or Friend)

**Notice of Nondiscrimination Statement:** Duke University Health System, and any duly authorized affiliates and subsidiaries (collectively "Duke Health") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity or expression.

**SPANISH (ESPAÑOL):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-919-681-3007.

**MANDARIN (繁體中文):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-919-681-3007.