

Authorization for Release of Information
Girl Scouts of San Jacinto Council

I. Information About the Use of Disclosure

I hereby authorize the use or disclosure of my daughter's identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Participant Name: _____ Camper Number: _____

Name of the plan authorized to provide the information: Girl Scouts of San Jacinto Council

Persons/organizations authorized to receive the information: (For example: *Mom, Stepfather, Grandparents*) _____

Specific description of information to be used or disclosed: (For example: *can release medical information to people listed above*) _____

Specific purpose of the disclosure: (For example: *put treatment or information*) _____

If a health plan or provider is requesting to receive the information described on this form, will that plan or provider receive financial or in-kind compensation in exchange for using or disclosing the health information described?

No _____ Yes (describe) _____

This authorization will expire one year from the date next to my or my personal representative's signature below, or upon the occurrence of the following event (**put camp dates here**) _____ (must relate to the purpose of the authorization).

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation not effect any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits to which I am otherwise entitled.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity and I understand that the information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (also known a HIPAA).

III. Signature of Parent/Legal Guardian

Signature of Parent/Legal Guardian
(Form **MUST** be completed before signing)

Date

Printed name of the participant: _____

Printed name of the participant's parent/legal guardian: _____

Relationship to the participant, including authority for status as representative: _____

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****