HIPAA AUTHORIZATION FORM

I hereby authorize the use or disclosure of my child's protected health information as described below:

1. JKHA Summer administrative staff is authorized to disclose any protected health information they deem relevant to the proper care of my child to appropriate JKHA Summer staff members.
2. The purpose of this use or disclosure is specific to the JKHA Summer program.
3. This Authorization Form is valid specifically during the time period of preparation of and the actual program dates when JKHA Summer is in session.
4. I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

By: _____ (Parent/Guardian Name - please print)

_____ (Parent/Guardian Signature)

For: _____ (Child's Name – please print)

Date: _____