BRILLION PUBLIC SCHOOLS
POLICY 532.31
Form C

Medical Authorization and Release

_____
(Name of Health Care Provider - Print)

I, _____, hereby authorize the above-referenced health care provider, or others to which I am directed for care relative to the health condition set forth above, to confer with medical representatives of the Brillion Public School District to clarify or supplement any information set forth herein without liability. I also authorize the use or disclosure of my health information (which may also be referenced as protected health information "PHI") as described in this authorization. I also agree to provide such further authorizations as the Brillion Public School District may request to process and classify my requested time off for FMLA Policy purposes.

Under this authorization, I authorize the above-identified health care provider to provide health information and/or PHI about me to the Brillion Public School District, District Administrator and its representative. I understand that after this information is disclosed to the District, federal law may not protect it and it may be disclosed to others.

I understand that I have the right to revoke this authorization at any time by notifying the above-referenced health care provider. I also understand that the revocation will only become effective after it is received and logged. I understand that any use or disclosure made prior to the time that such revocation becomes effective will not be affected by that revocation. Without regard to my right to revoke, this authorization will expire at the end of the latter of the processing or taking of my FMLA leave.

I understand that I am entitled to receive a copy of this authorization form and acknowledge receipt of one.

Dated this _____ day of _____, 20__.

_____
Signed

(Print):_____

Reviewed: 7/20/09