

The Health Insurance Portability and Accountability Act

Consent For the Use and Disclosure of Protected Health Information

In addition to the **Chief School Administrator** and the **School Medical Inspector**, I hereby consent to the use and disclosure of my Protected Health Information by the (*please check all that apply*):

- Principal
- School Nurse
- Payroll / Benefits Coordinator
- Personnel Secretary

in order to carryout Treatment or Payment. I understand that Protected Health Information means my health information, which is individually identifiable by name, social security number or date of birth.

I understand that uses and disclosures for Treatment and Payment include but are not limited to:

- Submit health information to the health insurance company in order to obtain payment for treatment or service rendered.
- Share health information with other health care providers in which I have a treatment relationship.
 1. Treatment: As a health plan, the Plans do not provide treatment services.
 2. Payment: The Plans may use and /or disclose your PHI in order to process payment, including receiving bills, or determining eligibility or coverage for the treatment and services provided to you

I understand that that terms of the HIPAA Notice of Privacy Practices may change and that I may request a revised notice by contacting the person listed above.

I understand that I have the right to request the Benefits Coordinator restrict how it uses and discloses my Protected Health Information in order to carry out Treatment and Payment. I understand that the Benefits Coordinator is not required to agree to the restrictions, but that if he or she agrees, the restriction is binding.

I understand that I have right to revoke this consent, but that I must do so in writing.

Signed: _____ Date: _____

Name (Print)_____

Black Horse Pike Regional School District
580 Erial, Road, Blackwood, New Jersey 08012
856-227-4106