Calloway County Schools

Authorization Form Regarding Employee Health Information

Name of Employee: _____ **School Year**: 2021-22

School/Department: _____

I have had an explanation of the requirements under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and understand that the Privacy Rule allows me as an employee of Calloway County Schools to determine what health information about myself and/or my family can be disclosed and to whom it may be disclosed.

Based upon this information, I request that the following guidelines be respected for myself and my family:

Please complete this section if you approve the disclosure of information by noting which statements you are in agreement with.

- ❑ In the event of an illness and/or my absence, the school/department may release information about my condition and/or the reason for my absence (e.g., having surgery or being ill).
- ❑ In the event of an illness and/or my absence, the school/department may release information about the reason for my absence related to my family members (e.g., having surgery or being ill).
- ❑ I would like to participate in my school/department's fund provided to send flowers/card to me or my family.

Please complete this section if you prefer that health information remain confidential by noting which statements you are in agreement with.

- ❑ In the event of an illness and/or my absence, the school/department should not release information about the reason for my absence (e.g., having surgery or being ill).
- ❑ In the event of an illness and/or my absence, the school/department should not release information about the reason for my absence related to my family members (e.g., having surgery or being ill).
- ❑ I do not wish to participate in my school/department's fund provided to send flowers/card to me or my family.
- ❑ I would like to participate in my school/department's fund provided to send flowers/card to **other** employees.

_____ _____

Signature of Employee Date