Dickinson Public School District #1
Health Insurance Portability and Accountability Act (HIPAA)
Release of Information Form

Employee Name:_____ SSN:_____

Building:_____ Date of Birth:_____

I hereby, authorize and volunteer the release of my Protected Health Information (PHI) to the Dickinson Public School's Privacy Officer for the purpose and duration listed below. I understand that this information will be kept confidential within the Human Resources Department for the sole purpose as stated. I further understand that I must furnish the Human Resources Department of the Dickinson Public Schools with the necessary medical information for them to act appropriately upon any leave application, sick leave bank application or other pertinent requests as listed below.

Signature:_____ Date:_____

Purpose of Release: _____
_____
_____
_____
_____
_____
_____
_____
_____

Duration of Release: _____
_____
_____
_____
_____
_____
_____

End of Dickinson School District #1 Exhibit DI-E

Date Issued: 03/02/04