

**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: \_\_\_\_\_  
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Duration of Release: \_\_\_\_\_  
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