NEWARK BOARD OF EDUCATION

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____(name) hereby authorize the use or disclosure of my health information as set forth below:

1. Person(s)/Entity(ies) authorized to provide information (Physician):

   _____

2. Person/Entity(ies) authorized to receive information:

   Office of Human Resource Services and Office of 504 Accommodations

3. Description of Information to be released:

   _____

I understand that I have the right to revoke this authorization at any time by notifying Newark Board of Education in writing to the Office of Human Resource Services, 765 Broad Street, Suite 2, Newark, NJ 07102. I understand that revocation is only effective after it is received and recorded by Newark Board of Education.

I understand that any use or disclosure made prior to revocation under this authorization will not be affected by a revocation.

I understand that after this information is disclosed, it may no longer be protected by federal or state privacy laws and the recipient may disclose it.

I understand that my initial and continued employment and position are subject to any agreement to this authorization if it is requested by Newark Board of Education.

I understand that I am entitled to receive a copy of this authorization.

I understand that this authorization expires when my employment is terminated, unless otherwise noted here _____ (alternate termination date).

Signature:_____ Date:_____
Employee/Family Member

If this form is signed by a personal representative, the signature represents that he or she has authority to sign because:

_____ (reason for authority).