Family Health Services	**Title:** HIPAA Acknowledgement Form	ID #: FD1003 Effective: 12/17/2025 Page: 1
	PHONE: 419-502-2800 • FAX: 419-502-2821	

PATIENT NAME:	**DATE OF BIRTH MM/DD/YYYY:**

Communication: FHS participates in one or more Health Information Exchanges. Health Information Exchanges are electronic networks used to securely provide access to the above-named patient's health records.

➡ _____ By initialing here, I consent to allow access to the above-named patient's health record through the Health Information Exchange.

➡ _____ By initialing here, I am authorizing FHS to leave a message on the above-named patient's answering machine or voicemail regarding scheduled appointments, pre-medication and instruction.

➡ I authorize the following person(s) to obtain medical information about the above-named patient. FHS is not responsible for the information provided if it is given to one/both people listed below.

☐ Check this box if you **do not** wish to have your information shared with anyone.

Name of Person Allowed to Receive Health Information:	Date of Birth (MM/DD/YYYY):
Phone Number:	Relationship to Above-Named Patient:
Name of Person Allowed to Receive Health Information:	Date of Birth (MM/DD/YYYY):
Phone Number:	Relationship to Above-Named Patient:

Use and Disclosure of Health Information: I have received the FHS Notice of Privacy Practices. If Federal Privacy Standards explain how FHS may use and disclose confidential health information that identifies the above-named patient.

By Signing Below I agree/consent to the following:

- I consent to the release of the above-named patient's health information and financial account information to all third-party payers and/or their agents that are identified by FHS, its billing agents, collection agents, attorneys or consultants. This includes other agents that represent FHS or aid FHS for the purposes of securing payment from all parties who are potentially liable for payment for the above-named patient's health care, including for substance abuse, psychiatric care or HIV, if applicable.

- If the above-named patient is a minor child, I authorize FHS to release all health information that is contained in the patient's record to the _____School District for treatment and otherwise needed for the above-named patient's safety and education at the sole direction of FHS. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and/or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below**. Release of Psychotherapy Notes requires a separate authorization to be completed. This authorization will automatically expire when **one** of the items below takes place:

    - HIPAA Acknowledgement Form will automatically expire annually
    - When FHS is no longer providing school-based health care services the School District mentioned above

- When the above-named patient is no longer a student at the School District mentioned above
- When I revoke this authorization.

- I can revoke my consent in writing at any time except to the extent that FHS has already relied on my consent by a written notice sent to:

  Family Health Services
  Attn: Administrator
  1912 Hayes Avenue
  Sandusky, OH 44870

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY*:	DATE:
PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY*:	RELATIONSHIP TO PATIENT:

*** IF SOMEONE OTHER THAN THE PATIENT IS SIGNING THIS FORM, A COPY OF LEGAL PAPERWORK VERIFYING THE PATIENT'S PERSONAL REPRESENTATIVE MUST ACCOMPANY THE CONSENT (I.E. COURT APPOINTED GUARDIANSHIP OF THE PATIENT OR DURABLE HEALTHCARE POWER OF ATTORNEY). THE ONLY EXCEPTION IS IF A PARENT IS SIGNING FOR A MINOR CHILD.**

** Psychotherapy Notes are defined as notes that document private, joint, group or family counseling sessions are separated from the rest of the above-named patient's medical record.