G-3133 © GCCG-EC

PROFESSIONAL / SUPPORT STAFF VOLUNTARY TRANSFER OF ACCRUED ANNUAL OR STRAIGHT LEAVE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Patient _____
Last First MI

I authorize the use or disclosure of the above individual's health information as described in this form.

The following Physician or Physician's office is authorized to make the disclosure.

_____

_____

Address _____

Specifically describe the illness or injury to be used or disclosed:

_____

This information may be disclosed to and used by the **CUBA INDEPENDENT SCHOOL DISTRICT** for the purpose of providing leave transfer.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to:

Cuba Independent School District Superintendent

I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authorization will expire on the following date _____
event _____ condition _____

If no expiration date, event or condition is specified, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. If I have questions about disclosure of my health information, I can contact the Superintendent of Schools.

_____ _____
Signature of Employee Date