AUTHORIZATION TO RECEIVE PERSONAL HEALTH INFORMATION

Employee's Name: _____

Employee Badge #: _____

Patient's Name: _____

Patient's Date of Birth: _____

Relationship to Member: _____

Employee's Authorization for Self or Minor Family Member

I am the employee described above and named in the Hays CISD employee's application for catastrophic leave benefits. I hereby authorize the Hays Consolidated Independent School District Catastrophic Leave Bank Committee to receive personal health information regarding any physical and/or mental health condition of myself or my minor family member named above as patient for the purpose of determining my eligibility for Catastrophic Leave Bank benefits.
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Signature of Member: _____ Date Signed: _____

Adult Patient's Authorization (Family Member)

I am the adult patient described above and named in the Hays CISD employee's application for catastrophic leave benefits. I hereby authorize the Hays Consolidated Independent School District Catastrophic Leave Bank Committee to receive personal health information regarding my physical and/or mental health condition for the purpose of determining the employee's eligibility for Catastrophic Leave Bank benefits.

Signature of Adult Patient: _____Date Signed: _____