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AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize McDonough County Health Department
(Name of Patient or Personal Representative)

To release the information listed below to: _____
(Name of Person to Receive Information)

_____
(Street Address) (City) (State) (Zip)

from the designated record set of _____whose birth date is_____
(Patient's Name)

and whose address is _____

The following information shall be released (mark all applicable):
____ Entire Medical Record or only individual items listed below (you must mark each of those to release)
____ Laboratory Results (Routinely Ordered Bloodwork may include Lead and Hemoglobin)
____ STI Records
____ HIV / AIDS Records
____ Immunization Records
____ Other: _____ .

The purpose of authorization is:
____ At the Request of the Individual or Personal Representative
____ Other: _____.

The information should be released for the following time period: from_____ to_____ .
(Start Date) (End Date)

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that if the health department has already used or released my health information in reliance on this authorization, that I cannot revoke the authorization. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by law.

I understand that this authorization is voluntary and the health department may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration listed below, or until I revoke it in writing by delivering a written revocation to the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of authorization if the health department is seeking this authorization.

This authorization for release of protected health information terminates on _____.
(Date)

Signature: _____ Date: _____

If you are not the patient, please state your relationship to the patient: _____.