AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete this form in its entirety. This authorization is not valid and the County will not release your protected health information unless the form is completed in its entirety. A copy of the signed authorization will be provided to you.

THE FOLLOWING PERSON(S) OR ENTITY SHALL:

Name of Person(s) or Entity: _____

Address of Person(s) or Entity:_____

TO DISCLOSE THE FOLLOWING INFORMATION FROM THE HEALTH RECORDS OF:

Name: (First/Middle/Last) _____

Address: (Street/City/ State/Zip code) _____

Birthdate: (Month/Day/Year)_____Social Security #: _____

Telephone Number: (Home)_____(Work) _____

THIS INFORMATION SHALL BE DISCLOSED TO THE FOLLOWING PERSON(S) OR ENTITY:

Name of Person(s) or Entity: _____

Address of Person(s) or Entity: _____

THE INFORMATION DISCLOSED SHALL COVER HEALTH CARE FOR THE FOLLOWING PERIOD(S) OF TIME:

From: (month/date/year)_____ To: (month/date/year) _____

From: (month/date/year)_____ To: (month/date/year) _____

THE INFORMATION SHALL BE DISCLOSED FOR THE FOLLOWING PURPOSE(S):
(Not required if the disclosure is requested by the individual. "At the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.)

_____

_____

_____

THE FOLLOWING INFORMATION SHALL BE RELEASED:

_____

_____

_____

_____

I UNDERSTAND THAT THIS WILL INCLUDE INFORMATION RELATING TO: (Initial, if applicable)

_____ Acquired Immunodeficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV).

_____ Behavioral health service/psychiatric care.

_____ Treatment for alcohol and/or drug abuse.

AFFIRMATION OF AUTHORIZATION:

I give the person(s) or entity named above permission to disclose only the information I have identified on this authorization form to the person(s) or entity I have named and only for the purposes I have identified. I understand: *(Please initial after reading each statement*)

_____ This authorization is valid for one year from the date I sign unless revoked prior to that date.

____ I may refuse to sign this authorization (A refusal to sign the authorization may effect payment for or eligibility for benefits).

____ I may revoke this authorization in writing at any time. (A revocation of this authorization may effect payment for or eligibility for benefits). This authorization cannot be revoked to the extent that the County has taken action in reliance on the authorization or the authorization was a condition of obtaining insurance coverage.

_____ This information may be redisclosed by the person(s) or entity receiving the information and no longer protected by 45 C.F.R. §164.508.

_____ I may access my protected health information by following the procedure outlined in the Notice of Privacy Practices.

_____

Signature of the Individual

Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

_____

Signature of personal representative Date

_____

Legal authority of personal representative