INGHAM COUNTY HEALTH DEPARTMENT

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____
Last First Middle Initial

Address: _____ **Phone:** _____
Street City State ZIP

I. I am the patient listed above or the legally authorized representative of the patient listed above. I request the release of my protected health information (or the information of the patient listed above) as follows:

From: _____
Person/Entity Authorized to Disclose this Information

_____
Address

_____
City State Zip

_____
Phone/Fax Number

To: _____
*Person/Entity Authorized to **Receive** this Information*

_____
Address

_____
City State Zip

_____
Phone/Fax Number

II. Specific Information to Be Released (From Date: _____ **To Date:** _____**)**

I request the following information to be released, which may include alcohol and drug abuse/treatment; social work counseling, HIV or AIDS status; communicable disease or infections (including sexually transmitted diseases, venereal disease, tuberculosis, and hepatitis), and demographic information, for the purpose and conditions designated on this form.

☐ Consultations ☐ Entire Medical Record ☐ Mental Health ☐ Substance Abuse Records
☐ Discharge Summary ☐ Inpatient Records ☐ Operative Reports ☐ X-Ray/Imaging Films/CD
☐ Emergency Room Reports ☐ Laboratory Tests/Results ☐ Progress Notes ☐ X-Ray/Imaging Reports
☐ Other (Specify): _____

III. Purpose of This Release/Disclosure (Check One):

☐ At the request of the patient (or patient's legally authorized representative); OR
☐ At the request of someone other than the patient for the following purpose(s):
☐ Attorney/Legal ☐ Insurance ☐ Social Security/Disability Certification
☐ Worker's Compensation ☐ Other: _____

I ACKNOWLEDGE that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, the information above may be disclosed by them and no longer protected by the privacy regulations.

I ACKNOWLEDGE that I may revoke this Authorization in writing at any time by contacting the disclosing party (ICHD or other entity). Revocations will not apply to information that already has been released.

I ACKNOWLEDGE that I have read the above, and that I understand the terms and conditions of this Authorization. I understand that the Ingham County Health Department may not require me to sign this Authorization as a condition for treatment, for payment, for enrollment, or for eligibility for benefits.

This Authorization expires on: _____ **or six (6) months after the date signed below if left blank.**
Specify Expiration Date

NAME (Printed): _____

RELATIONSHIP TO THE PATIENT (If Applicable): ☐ Parent ☐ Legal Guardian ☐ Other (proof of legal authority may be required)

SIGNATURE: _____ **DATE:** _____