CRAWFORD COUNTY HEALTH DEPARTMENT
AUTHORIZATION FORM
OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize Crawford 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 except items listed below (you must mark each of those to release)

_____ Mental Health Treatment Records
_____ Alcohol or Other Drug Treatment Records
_____ HIV/AIDS Records
_____ Immunization Records
_____ Other: _____.

_____ Genetic Information
_____ Laboratory Reports
_____ X-Ray or Other Photographic Reports
_____ Sexual Assault Treatment Records

The purpose of the 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 this provider. I understand that if the provider 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 provide by law.

I understand that this authorization is voluntary and this provider 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 this provider.

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

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

Signature: _____ Date: _____

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

Reviewed 11/16