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Authorization to Release or Obtain Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

Phone Number: _____ Social Security Number: _____-_____-_____

I hereby authorize:(*Name of facility*)_____

(*Address*)_____

(*Phone*)_____(*Fax*)_____

To release PHI to:(*Name of facility*)_____

(*Address*)_____

(*Phone*)_____(*Fax*)_____

I hereby authorize Jefferson County Health Department to release/request the following information contained in my medical records and hereby release (*name of facility releasing records*) _____ from all legal liability that may arise from further disclosure of said records.

___ Lab Reports ___ X-ray Reports ___ Sexually Transmitted Diseases (STD)

___ Immunization Records ___ AIDS / HIV ___ Pap Results

___ Drug and Alcohol Abuse Information ___ Other (please specify) _____

For date(s) of service (*specific date or range of dates/years*): _____

- You may refuse to sign this authorization. Refusal to sign will not jeopardize your right to obtain treatment except unless it is necessary for your treatment or to submit a claim for payment to someone other than you.
- This authorization may be revoked in writing at any time by the patient in person or by mail.
- The revoking of this authorization shall not cancel any prior action that has already been taken.
- This authorization shall remain in force for a period of one year from date of form completion unless otherwise stated as follows:_____
- You are entitled to receive a copy of this completed authorization form.

Signature of Patient: _____ Date_____/_____/_____

Signature of Legal Representative: _____ ____ Date: _____/_____/_____

Relationship (and proof of it) to Patient: _____

Signature of Witness: _____ Date: _____/_____/_____

INTERNAL USE ONLY

Date released:_____/_____/_____ __mail __ fax __pickup

Signature of staff person releasing the information:_____