Jay County Health Department

Authorization for Release of Medical Information

Patient Name (Print): _____ Date of Birth: _____
Phone: (home/cell) _____
Address: _____
City: _____ State: _____ Zip: _____

I, the undersigned, authorize and request the Jay County Health Department to:
Check One: [ ] Release To; [ ] Obtain From
Person/organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ FAX: _____

The following information from my medical records for care/treatment that I received from:
Name: _____, from: _____ until discharge or through _____.
Check One: [ ] Any/all, or as much information as the releasing healthcare provider, in its sole discretion, deems reasonably necessary for the purposes set forth by me for release.
[ ] Specific Exclusions: _____
Purpose for Disclosure: _____

This authorization is effective for _____ or no longer than 1 year from the date on which it is signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Chief Privacy Officer at Department. A photocopy or facsimile of this release shall have the same effect as an original. I understand I have the right to inspect the information to be disclosed, and include my written statement about the record, upon proper notification to and under appropriate conditions established by Department. I acknowledge that the information to be released may include material that is protected by State and Federal Law applicable to either mental health, and/or drug and/or alcohol abuse and/or HIV/AIDS, and my signature authorizes release of such information, unless exceptions have been stated above. Initials: _____

_____	_____	_____	_____	_____
Signature of patient or Representative	Date	Relationship to Patient	Witness	Date

(A copy of this signed form must accompany released information.)

Release Processed (Initials): _____ Date: _____

PROHIBITION FOR RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal and/or State Law. The Authorization for Release of Medical Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, and State Law for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such laws and/or regulations. A general authorization for the release of medical information is NOT sufficient for these purposes. Civil and Criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/SIDS information.