JEFFERSON COUNTY HEALTH DEPARTMENT

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Administrator

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Protect Health, Prevent Illness, and Promote Wellness

RELEASE OF INFORMATION FORM

I, _____ hereby authorize ***Jefferson County Health Department*** to
(**Name of Patient or Personal Representative)**
release the information listed below to: _____
(**Name of Person/Agency to Receive Information)**

_____
(Street Address) **(City)** **(State)** **(Zip)**

_____
(Phone Number) **(if requesting fax service, please provide fax number)**

from the designated record set of _____ whose birth date is _____.
(Patient's Name)

The following information shall be released (mark all applicable):
_____ **Immunization Records**
_____ **Other:** _____.
_____ **Other:** _____.

The purpose of the authorization is:
_____ **At the request of the individual or personal representative**
_____ **Other:** _____.

The information should be released for the following dates: _____ - _____.
(**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 provided 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 not the patient, please state your relationship to the patient: _____.