

POSEY COUNTY HEALTH DEPARTMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM THE POSEY COUNTY HEALTH DEPARTMENT

_____/_____/_____
Client Name (Printed) Maiden Name/Alias Date of Birth Phone Number

Client's Street Address (IC 16-39-1-4) City, State, Zip code

I hereby authorize the Posey County Health Department to use and disclose the protected health information of the above named individual to: _____

Client/ Agency/ Representative Phone Number Fax Number

Client/Agency/Representative Street Address City, State, Zip code

For the following purpose(s) (CHECK ALL THAT APPLY):

_____ at my request
_____ other: _____
(Describe purpose)

The information requested may relate to and include (CHECK ALL THAT APPLY):

- Immunization Treatment
 Continuing Medical Outcome of care
 Progress Notes Claim for reimbursement
 Assessment
 Litigation against a third party other than the Health Department, a Health Department employee or physician
 Litigation against the Health Department, a Health Department employee or physician
Specify Person: _____
 Other (Please describe): _____

DATES OF CARE: INCLUDED/FROM ____/____/____ TO ____/____/____

I understand that the information used or disclosed may be subject to re-disclosure by the agency or other entity receiving it and may no longer be protected by federal privacy regulations.

I understand that I may revoke my consent by notifying the Posey County Health Department in writing of my stated desire to revoke it. Such revocation will not apply to information previously disclosed.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my health care or treatment by the Posey County Health Department.

This authorization shall expire 60 days from the day signed. Upon completion, a copy of this signed authorization will be provided to me at my request.

Signature of Client/Personal Representative

Witness

Relationship of Personal Representative

Date