TCHD Medical Clinic
STANDARD AUTHORIZATION TO DISCLOSE INFORMATION

I (patient's name) _____(Date of Birth)_____authorize the **Tuscarawas County Health Department** to: ☐ disclose; ☐ receive; ☐ exchange information with:

Agency/Name of Person	
Address	
Phone	
Fax/Email	

TYPE OF INFORMATION TO BE DISCLOSED:

Certain information is covered by additional protection and requires specific authorization: if you would like the below information released, each item will have to be separately initialed and dated

☐ Alcohol or Drug use/abuse Treatment
☐ Mental Health Treatment
☐ HIV Status or Treatment
☐ Minors receiving services for Reproductive Health (Title X)

This authorization expires 1 (one) year from signature unless sooner as noted here: _____

_____
Signature of patient **Date**

_____
Signature of parent, guardian or authorized representative - if required **Date**

_____
Signature of staff or witness **Date**

REVOCATION: This authorization is subject to written revocation at any time except to the extent the Program or person who is to make the disclosure has already acted in reliance on it.

I hereby revoke consent: _____
Patient/Authorized Representative Signature **Date**

_____
Signature of staff or witness **Date**

Public Health
Prevent. Promote. Protect.

Tuscarawas County Health Department
897 East Iron Avenue
Dover, Ohio 44622
Fax: (330) 343-1601