# TUSCARAWAS COUNTY GENERAL HEALTH DISTRICT

## Authorization for Release of Health Information

**Patient Name** ___________________________________ **Date of Birth** _______________

**The above named person must indicate when this authorization is to expire: (Choose One)**

____ When information is received
____ In six months
____ On date _____________________________
____ In one year
____ In three years

**The person named above is or has been a patient of:**

Name of Provider
Or Facility ______________________________________________________________
Address ________________________________________________________________
Phone__________________________________________________________________
Fax ____________________________________________________________________

**The person named above hereby authorizes The Tuscarawas County Health Department located at 897 East Iron Avenue Dover, Ohio 44622. (Choose all that apply)**

____ Request health information from: _______________________________________
____ Send information to:_______________________________________________
____ Discuss health information with: _______________________________________

*Continued on back*

897 East Iron Avenue
Dover, Ohio 44622

PHONE (330) 343- 5555
FAX (330) 343-1601
EMAIL tusccohd@odh.ohio.gov
WEB SITE www.tchdnow.org

**Scope (Choose One)**

____ All information regarding assessment, diagnosis and treatment of patient's condition, disease or concern (specify): ____________________________________

____ All information regarding care received by the patient between the dates of ________________ & ______________

____ Other information (specify): __________________________________________

**Certain information is covered by additional protection and requires specific authorization: If you would like the below information release each item will have to be separately initialed and dated.**

| Initial | Date | |
|---|---|---|
| _________ | ____________ | Alcohol or Drug use/abuse Treatment |
| _________ | ____________ | Mental Health Treatment |
| _________ | ____________ | HIV Status or Treatment |
| _________ | ____________ | Minors receiving services for reproductive health (Title |

**Authorization:**

______________________________________________________________

**Printed Name of Patient or Authorized Representative**

_________________________________________ ____________________

**Signature of Patient or Representative** **Date**

______________________________ ______________________________

**Relationship to Patient** **Witness**

The person named above has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request.
- You have a right to inspect any information you are authorizing to be re-released.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. We are not responsible for the actions of others who may be provided with information as a result of this authorization.
- You may refuse to sign this authorization. Your refusal to sign will not affect your service.

There may be a fee associated with the copying of your records.

Revised 2/4/16 KS