Form: 2023-08

Tuscarawas County Health Department
Medical Clinic
Authorization for Release of Medical Information

Patient Name:	Date of Birth:
Address:	
Phone Number:	

I hereby authorize the Tuscarawas County Health Department to furnish and receive medical information concerning the above Patient To and/or From:_____

Please circle To or From to indicate desired flow of records. (Ex. Medical office, parent of a minor, family member)

Phone Number:_____ Fax Number:_____

Any and all information may be released, including but not limited to, mental health records protected by the Lanterman-Patris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as provided below:

_____

_____

The information released may be used for the following purposes: *(select all that apply)*

_____ to coordinate treatment
_____ insurance
_____ employment
_____ personal use
_____ other: _____
_____ payment/billing information
_____ legal reasons
_____ disability
_____ prescriptions

This authorization is effective now and will remain in effect for one (1) year from date of signature, unless otherwise revoked.

I understand that TCHD shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I MAY REFUSE TO SIGN THIS AUTHORIZATION.

_____ _____
Signature of Patient or Legal Guardian Date

STOP: Sign below only if you want to revoke the above Release of Medical Information

Revocation: This authorization is subject to 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. Patient can revoke consent either verbally or in writing.

I hereby **revoke** my consent on *(date)* _____

_____ _____
Signature of Patient or Legal Guardian Date

12/05/2022 KS, 06/07/2023 CRM