



**Public Health**  
Prevent. Promote. Protect.

Tuscarawas County Health Department

## 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 medical information concerning the above Patient to: \_\_\_\_\_

Phone Number: \_\_\_\_\_ (Ex. Medical office, parent of a minor, family member)

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)*

- |  |  |
|--|--|
| <input type="checkbox"/> to coordinate treatment | <input type="checkbox"/> payment/billing information |
| <input type="checkbox"/> insurance               | <input type="checkbox"/> legal reasons               |
| <input type="checkbox"/> employment              | <input type="checkbox"/> disability                  |
| <input type="checkbox"/> personal use            | <input type="checkbox"/> prescriptions               |
| <input type="checkbox"/> other: _____            |  |

This authorization is effective now and will remain in effect for (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