Tuscarawas County Health Department
Authorization to Release and/or Exchange Information

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

I, the undersigned, hereby authorize the Tuscarawas County Health Department **to use or disclose** my personal health information and/or confidential information as described below to:

Name of Person or Entity: _____ Phone:_____ Fax:_____

Address: _____ City:_____ State:_____ Zip:_____

☐ **If marked, I further authorize the EXCHANGE of information and for the party identified as person or entity above to also disclose my personal health information and/or confidential information to the Tuscarawas County Health Department.**

Type of Information to be released/exchanged (select all that apply):

☐ History/Physical Notes ☐ General Medical Records ☐ General Lab Results
☐ Medication List ☐ Immunization Records ☐ Substance Use Disorder Urinalysis Results
☐ STD/STI Lab Results ☐ HIV/AIDS Related Diagnosis ☐ Billing/Payment Information
☐ Other: _____

Dates of Service to Release (FROM): _____ (TO): _____

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

☐ To Coordinate Treatment ☐ Insurance ☐ Legal Reasons ☐ Employment
☐ Disability ☐ Personal Use ☐ Other: _____

I understand the following:

- That the requested information may contain information regarding physical and mental illness, HIV test results or diagnosis, AIDS, or AIDS related conditions, alcohol and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.
- 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 if requested in writing.
- 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 because 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 and accept responsibility for those charges.
- 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.
- The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.

This authorization is effective now and will remain in effect until (date): _____

Failure to specify an expiration date will result in this authorization expiring one (1) year from date of signature.

_____ _____ _____

Signature of Patient/Parent/Legal Guardian **Printed Name** **Date**

*Prohibition Against Re-disclosure: 42 CFR part 2 prohibits unauthorized disclosure of these records. This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose (see 2.31). except as provided at 2.12 (c- (5) and 2.65. **If other than client's signature, a copy of legal paperwork verifying the client's personal representative MUST accompany the request unless otherwise on file with provider (e.g., court appointed guardian, durable power of attorney for healthcare, grandparent power of attorney). Exception: Parent signing for client under the age of eighteen and the County agency holding custody.

REVOCATION: ONLY FILL OUT IF YOU ARE NOT CONSENTING TO THE ABOVE OR DECIDE TO REVOKE THIS CONSENT

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.

I hereby revoke my consent on (date):_____ Signature of Patient/Parent/Legal Guardian: _____