KENTON-HARDIN HEALTH DEPARTMENT
Public Health
Prevent. Promote. Protect.

Kenton-Hardin County Health Department 175 W. Franklin St., Suite 120 Kenton OH 43326
Office: 419-673-6230 Fax: 419-673-8761

AUTHORIZATION TO RELEASE INFORMATION

I, _____ of _____ _____
Parent/legal guardian Name/Self | Client Name | Client Birth Date

_____ _____
Address | Phone Number

_____ _____
Signature | Date

Release Information to: _____ (relationship to client, if any) _____

_____ _____ _____
Address | Phone Number | Fax Number

Reason for Request: (PATIENT CARE___) (INSURANCE___) (SELF___) (SCHOOL___) (OTHER: _____)

I AUTHORIZE DISCLOSURE OF THE FOLLOWING PROTECTED HEALTH INFORMATION:

☐ Immunization Record ☐ Medical Records ☐ Hemoglobin & Lead Testing Results
☐ TB Test Results ☐ Laboratory Results ☐ Medication Records
☐ Other _____ ☐ Entire Medical Record ☐ Name, Address & Phone Number

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOACTION TO THE PRIVACY OFFICER. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT OR CONDITION: _____.
IF I FAIL TO SPECIFY AN EXPIRATION DATE, EVENT OR CONDITION, **THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE ON WHICH IT IS SIGNED.**

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION. I NEED NOT SIGN THIS FORM IN ORDER TO ASSURE TREATMENT. I UNDERSTAND THAT I MAY INSPECT OR COPY THE INFORMATION TO BE USED OR DISCLOSED, AS PROVIDED IN 45 C.F.R. 164.524. I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED RE-DISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES.

_____ _____
Signature of Client or Legal Representative | Date

_____ _____ _____
If Signed by Legal Representative, Relationship to Client | Employee Signature | Date