

Clermont County Public Health
2400 Clermont Center Drive, Suite 200
Batavia, OH 45103
Authorization for Release of Information

Client Information:

Client Name: _____

Date of Birth: _____

Social Security or Medical Record #: _____

Authorization:

I hereby voluntarily authorize Clermont County Public Health to use, release, or disclose the above named individual's protected health information. I understand that I do not need to sign this form to receive services. The information to be disclosed is as listed below: (Please be specific)

I authorize disclosure of the above listed information to the following individual or organization:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Purpose:

The purpose of the release of this information is: _____

I understand that once the information is disclosed, there exists the possibility of unauthorized re-disclosure by the recipient and the information may not be protected by federal privacy laws or regulations. The Health District will not be held responsible for any subsequent disclosure by the recipient of the health information.

I understand that I have the right to cancel this authorization at any time by presenting my written request for cancellation to the Nursing Director, or designated representative, at the Health District. Unless I cancel sooner, this authorization will expire on the following date: _____. If I do not specify a date, the authorization will expire 12 months from the date this form is signed. I understand the revocation will not apply to information that has already been released in response to the authorization.

Client Signature: _____ Date: _____

Client Legal Representative: _____ Date: _____

If signed by legal representative, relationship to client: _____

You are to receive a copy of this signed authorization to keep for your records.