Authorization for Release of Medical Information

Patient Name (Print): _____ DOB: _____

Social Security: _____ Phone (home/cell): _____ (work)_____

Address: _____

City: _____ State: _____ Zip: _____

I, the undersigned, authorize and request Douglas County Health Department to Release To/Obtain From the following:

_____

_____

_____

_____

_____

This authorization is effective from the date on which it is signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Chief Privacy Officer at the Department. A photocopy or facsimile of this release shall have the same effect as an original. I understand I have the right to inspect the information to be disclosed, and include my written statement about the record, upon paper notification to and under appropriate conditions established by the Department. I acknowledge that the information to be released may include material that is protected by State and Federal Law applicable to mental health, and/or drug and/or alcohol abuse and/or HIV/AIDS, and my signature authorizes release of such information, unless exceptions have been stated above. **Initials: _____**

_____ _____ _____

Signature of patient or Representative **Date** **Relationship to Patient**

(A copy of this signed form must accompany released information)

Release Processed (Initials): _____ **Date: _____**

PROHIBITION FOR RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal and/or State Law. The Authorization of Medical Information form does not authorize re-disclosure of medical information beyond the limits of this consent.