Public Health
Prevent. Promote. Protect.
MORGAN COUNTY HEALTH DEPT.

Morgan County Health Department
4275 N SR376 NW
McConnelsville, OH 43756
Phone: 740-962-4572
Fax: 740-962-3271

Authorization to Disclose Health Information

Name: _____ DOB: _____

I, _____, (*Client, Patient or Personal Representative*)

hereby authorize the Morgan County Health Department to disclose specific and identifiable health information from the records of the above-named person to:

_____

_____

(Recipient Name/Address/Phone/Fax):

for the specific purpose(s) of:

_____

_____

Specific information to be disclosed:

_____

_____

This authorization will expire on the following date, event or condition:

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time. I further understand that any action taken by the Morgan County Health Department in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____ _____ _____
(Signature of Client/Patient) *(Date)* *(Witness-If Required)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Relationship/Authority)*

***********NOTE:** This Authorization was revoked on:*

_____ _____
(Date) *(Signature of Staff)*