Authorization Form for Release of Health Information
District Health Department #10

Client Name: ____
Last First MI Maiden or other Name

Address: ____________________ Birth Date: __________ Phone: __________

City: ____________________ State: __________ Zip: ____________________

I hereby authorize District Health Department #10 (DHD#10) to:

❑ ***get information from:*** **OR** ❑ ***release my health information to:***

Name: ____

Address: ____________________ City: __________ State: ______ Zip: ______

Phone: ____________________ FAX : ____________________

Please Fax/Send my information to DHD#10 at: ______________________________

Health Information to be Released: *I specifically authorize release of the following information as checked*

❑ HIV-related information (AIDS related testing)
❑ Communicable Disease

Family Planning Program:

❑ Last Pap test result and any abnormal pap test results
❑ Copy of last complete exam
❑ Copy of breast evaluation
❑ Date of last dep-provera injection
❑ Notes of evaluation for hormonal birth control
❑ Notes of referral evaluation
❑ Colposcopy, biopsy results, treatment
❑ Other____________________

❑ Immunization Records
❑ Hearing & Vision Test Records
❑ MIHP Client Record

W.I.C. Program:

❑ Height/Weight/Head Circumference
❑ Lead Test Results
❑ Hemoglobin Test Results
❑ Counseling Notes
❑ Special Diet Information
❑ Health & Dietary History Forms
❑ Other____________________

This authorization is made for the following purpose:

❑ At my request **OR** ❑ At the request of (specify):

CONDITIONS OF AUTHORIZATION:

1. This authorization will expire one year from the date of signature, or on ____________________.
2. I may revoke this Authorization at any time by notifying DHD#10 in writing, and it will be effective on the date notified except to the extent that DHD#10 has already acted upon such Authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal HIPAA Privacy regulations.
4. I understand that DHD#10 will not condition my healthcare, payment for my healthcare, enrollment or eligibility for benefits on whether I sign this authorization or not.
5. I have been offered a copy of this signed Authorization.

______________________________ OR ______________________________

Signature of Patient Date Authorized Person & Relationship (parent/guardian) Date

____

Witness Signature Date

11/06

FOR OFFICE USE ONLY

Date Request Filled: ____________________ By: