RELEASE OF HEALTH INFORMATION
Authorization Form

District Health Department #10

Client Name: _____
Last First M.I Maiden Name or Other Name

Date of Birth: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

I hereby authorize District Health Department #10 to:

☐ Obtain Information **From** **OR** ☐ Release My Health Information **To**

Name: _____

Address: _____ City/State: _____ Zip: _____

Phone: _____ Fax: _____

Name: District Health Department #10 (DHD#10)

Address: _____ City/State: _____ Zip: _____

Phone: _____ Fax: **231-845-9374**

*Please **FAX** my information to District Health Department #10: **231-845-9374***

I specifically authorize the Health Information to be released as checked:

- ☐ STD
- ☐ HIV (AIDS-Related Testing)
- ☐ Communicable Disease
- ☐ MIHP Client Record

Family Planning & Cervical Program

- ☐ Last pap test result and any abnormal test results
- ☐ Copy of last complete exam
- ☐ Copy of breast evaluation
- ☐ Date of Last Depo-Provera Injection
- ☐ Notes of Evaluation for Hormonal Birth Control
- ☐ Notes of Referral Evaluation
- ☐ Colposcopy/Biopsy Results
- ☐ Laboratory Results
- ☐ Other: _____

- ☐ Immunization Record
- ☐ Hearing & Vision Test Records
- ☐ CSHCS
- ☐ Adolescent Health Center (Specify)-

WIC Program

- ☐ Height/Weight/Head Circumference
- ☐ Lead Test Results
- ☐ Hemoglobin Test Results
- ☐ Counseling Notes
- ☐ Special Diet Information
- ☐ Health & Dietary History Forms
- ☐ Other: _____

Conditions of Authorization:

This authorization is made

☐ At **MY** Request **OR** ☐ At the Request of *(Specify)* - _____

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 been 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 Client Date Authorized Person & Relationship *(Parent/Guardian)* Date

_____
Witness Date

OFFICE USE ONLY

Date Request Filled: _____ By: _____