Health and Hospital Corporation of Marion County
Marion County Public Health Department

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize ____________________ to release the following from my medical/health record concerning care, treatment, payment or services.

Date of Birth: ____________________ (MM/DD/YYYY) MCPHD #: ____________________

Print Client/Patient Name: ____________________ (Last) (First) (MI)

Address: ____________________ (Street) (City) (State) (Zip)

Print name of person making request: ____________________

The following information may be released:

- ☐ History
- ☐ Immunizations
- ☐ Progress notes
- ☐ Doctor's notes
- ☐ Clinic notes
- ☐ Summary
- ☐ HIV testing/AIDS related conditions
- ☐ Substance abuse, diagnosis and
- ☐ treatment
- ☐ Tests/results
- ☐ Social work/counseling
- ☐ STDs
- ☐ Mental health diagnosis and treatment
- ☐ Other ____________________
- ☐ All the above

This authorization for release of information applies only to the following Health and Hospital Corporation/Marion County Public Health Department site: ____________________

The above information may be released to : ____________________
Name of person or organization

Address: ____________________ (Street) (City) (State) (Zip)

Purpose for Disclosure: ____________________

Note to recipient of information: Health information may not be shared with others without specific written consent of the person to whom it pertains.

I hereby state that I have read and fully understand the above statements as they apply to me. This authorization will expire one year after the date below, or sooner by my choice, in which case this will expire on ____________________ .

I understand that this authorization is subject to written revocation at any time except to the extent that action has been taken in reliance on the authorization. HHC/MCHD ______ ***will*** *______* ***will not*** condition treatment, payment, enrollment or eligibility for benefits on *this authorization. I also understand the potential for information disclosed pursuant to the authorization is subject to redisclosure by the recipient.*

Client/Patient or Legal Representative (Print): ____________________ Date: __________

Client/Patient or Legal Representative Signature: ____________________

Authority of Legal Representative to consent for client/patient: ____________________

Witness: ____________________ Date: __________

For Internal Use Only

________Approved ______ Denied Date: ____________________

Reason for Denial ____________________

____________________ Released by Authorized Employee Name (Print)

____________________ Title

____________________ Authorized Employee Signature