CALDWELL COUNTY HEALTH DEPARTMENT

Last Name **First Name** **MI**

Date of Birth: _____/_____/_____

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

By signing this form, I hereby authorize:

Name: Caldwell County Health Department
Address: 2345 Morganton BLVD SW Lenoir, NC 28645
Phone: (828)426-8488 Fax: (828)426-8503

To disclose specific health information from the records of the above named client to:

Name: _____
Address: _____
Phone: _____Fax:_____

For the specific purpose(s):_____

_____

Specific health information to be disclosed: _____

_____

Covering the period(s) of healthcare: from _____ to _____

I understand that my medical record may contain information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions and that this disclosure may include that information.

I understand that I may refuse to sign this Authorization and that refusal to sign will not affect my ability to obtain treatment, payment for services, enrollment in a health plan, or my eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be re-disclosed by the person or agency that receives it.

I understand that I have the right to revoke this Authorization at any time except to the extent that action based on this authorization has taken place. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization as well as exceptions to my right to revoke, are explained in LCHD Notice of Privacy Practices, a copy of which has been provided to me.

I understand, unless otherwise revoked, this authorization will expire: _____
(Date or event related to the purpose of authorization)

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

_____ _____ _____
Signature of patient OR authorized representative Relation to Patient Date

_____
Witness signature (staff member)

CCHD
01/14
C:\Users\lclark\Documents\CONSENTS AND MEDICAL RELEASES\MEDICAL RELEASES\BLANK MEDICAL RELEASE.doc