AUTHORIZATION FOR RELEASE OF INFORMATION
HENRY COUNTY HEALTH CENTER
HEALTH INFORMATION SYSTEMS

Name: ____ Date of birth: _____________________

I, the undersigned, hereby authorize _____________________________________ to disclose and/or deliver to:

____
(Name of person and/or institution)

____
(Address)

A copy of the following reports: (please include dates)

____

____

____

I understand that the information is to be used for:

____

1. This authorization is voluntary.
2. This authorization will expire 1 year from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to reviewing the revocation.
4. I agree to waive all claims against the facility for release of the requested information
5. I understand that I must provide the facility with at least a twenty-four hour (24 hour) notice before coming to the facility to review records.
6. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or business associate that has a contract with the facility.
7. I understand that after I have reviewed the records, I must provide the facility with two (2) working days advance notice of any copies of the records that I would like to pick up at the facility.
8. I understand that if I request that records be copies and sent to me that the facility will make a good faith effort to send those records to me in a reasonable amount of time.
9. I understand that if I wish to have copies of records made, then the facility will asses a reasonable fee for copying the records.
10. The facility will notify me of the total amount due for copying and shipping of the requested records; I agree that the facility will only send me the requested information once it has received payment in full for those costs.

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This authorization is subject to revocation in writing and will expire within 1 year from the date of signature. I understand that there may be a charge for the copying of my medical record information.

Signature of patient or legal guardian ______________________ Date ____________

Relationship ______________________

Address ______________________ Witness ______________________

City State Zip ______________________ Witness **(two needed if VERBAL)** ______________________

Specific authorization for release of information protected by State or Federal Law.

I specifically authorize the release of data and information relating to: {check appropriate box(es)}

1. Substance Abuse ☐
2. Mental Health ☐
3. HIV Relation Information ☐

In order for this information to be released you must sign above and below.

Name ______________________ Date ____________

Henry County Health Center