Authorization to Disclose Health Information

Name ____ Date of Birth___________________________

I, ____*(Client, Patient, or Personal Representative)*, hereby **authorize** the following entity(ies) *(Name/Address/Phone/Fax)*:

____

____

____

to disclose specific and identifiable health information from the records of the above named person to the **Ohio Department of Health** for the specific purpose(s) of:

____

____

Specific information to be disclosed:

____

____

This authorization will expire on the following date, event or condition:

____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken by the above named entities or the Ohio Department of Health in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

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

______________________________	______________	______________________________
(Signature of Client/Patient)	*(Date)*	*(Witness-If Required)*
______________________________	______________	______________________________
(Signature of Personal Representative)	*(Date)*	*(Relationship/Authority)*

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NOTE: This Authorization was revoked on:

______________	______________________________
(Date)	*(Signature of Staff)*

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of ________________________________
(Name of Client/Patient)

signed by____ on _______________________________________
(*Enter Name of Person Who Signed Authorization)* *(Enter Date of Signature)*

be rescinded, effective _______________________.
(Date)

I understand that any action taken by the named entity(ies) or the Ohio Department of Health in accordance to this authorization prior to the revocation date is legal and binding.

____________________________________	_________	_________________________________	________________
(Signature of Client/Patient)	*(Date)*	*(Signature of Witness)*	*(Date)*

____	____________	____
(Signature of Personal Representative)	*(Date)*	*(Relationship/Authority)*