Darke County General Health District
T. L. Holman, DVM, REHS, Health Commissioner

Contributing to a Stronger Healthier Community

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME:_____ _____ ____ _____
(Last) (First) (MI) (Maiden or other name)

DATE OF BIRTH: ____-____-____ SS# _____-_____-_____ BCMH CASE#_____
(Mo) (Day) (Yr)

ADDRESS: _____ _____CITY: _____STATE:_____ZIP:_____

DAY PHONE: _____EVENING PHONE:_____

I hereby authorize the Darke County Health Department to release/obtain my health information to the following agency or person:

☐ **OBTAIN INFORMATION FROM**
OR
☐ **RELEASE INFORMATION TO**

☐ **OBTAIN REQUESTED INFORMATION FROM**
OR
☐ **SEND REQUESTED INFORMATION TO**

Name: _____
Address: _____
City: _____ State: ___ Zip:_____
Phone: _____ Fax: _____

Darke County Health Department
300 Garst Avenue
Greenville, OH 45331
Attention:_____

HEALTH INFORMATION TO BE RELEASED OR RESCINDED	
I specifically authorize release of the following information	**Rescind date**
☐ Immunization records	
☐ Entire Medical Record, OR (check appropriate box (s)	
☐ History and physical exam	
☐ Progress notes	
☐ Lab, x-ray reports	
☐ Mental health (including psychotherapy notes)	
☐ Consultations	
☐ HIV related information (AIDS) related testing)	
☐ Animal Bite Report	
☐ Other:	

This Authorization is made for the following purpose: ☐ At my request; or

☐ Specify:_____

1. This Authorization will expire six years from this date or on: _____
2. I may revoke this Authorization at any time by notifying Darke County General Health District in writing, and it will be effective on the date notified except to the extent that Privacy Practice of Darke County General Health District has already 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 privacy regulations.
4. By authorizing this release of information, my healthcare and payments for my healthcare will not be affected if I do not sign this Authorization form.
5. I have been offered a copy of this signed Authorization form.
6. [If this Authorization is for Marketing, add the following:] I have been informed that Darke County General Health District will/will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

_____/_____ OR _____ /_____
(SIGNATURE OF PATIENT) (DATE) (PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON) (DATE)

FOR OFFICE USE ONLY
DATE REQUEST FILLED:_____BY:_____
FORM OF IDENTIFICATION:_____

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Environmental Fax: 937-548-9654
Nursing Fax: 937-548-9128
Website: www.darkecountyhealth.org
Email: darkecohd@darkecountyhealth.org