## Darke County General Health District

E. L. Holman, DVM, RS, Health Commissioner



Contributing to a Stronger

Healthier Community

AUTHORIZATION FOR	DELLYCE	OFBEATTE	TNEODMATION
AULIORIZATION FOR	KELEASE	OF HEALIH	DYFORIVLATION

PATIENT NAME:  (Last) (First)  DATE OF BIRTH: - SS# -  (Mo) (Day) (Yr)		们) (Maiden or other name) CMH CASE⊭	
(Mo) (Day) (Yr) ADDRESS:	CITY:	STATE: ZIP:	
DAY PHONE: EV	ENING PHON	E:	
hereby authorize the Darke County Health Department to rele	ase/obtain my	health information to the following agency	or person
OBTAIN INFORMATION FROM OR	□ ОВТА	IN REQUESTED INFORMATION FROM OR	
☐ RELEASE INFORMATION TO	☐ SEND	☐ SEND REQUESTED INFORMATION TO	
o.		Darke County Health Department	
P66.		300 Garst Avenue	
ess: State: Zip:			
E: Fax:		Attention:	
	······· ,		
HEALTH INFORMATION TO B			
I specifically authorize release of the following in	formation	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)			
Other:			
This Authorization is made for the following purpo	ese:	At my request; or	
This Authorization will expire six years from this date or on:			
I may revoke this Authorization at any time by notifying Darke Co	ounty General H	lealth District in writing, and it will be effective	ve on the
notified except to the extent that Privacy Practice of Darke County	General Health	District has already acted upon such Authori	zation.
Information used or disclosed pursuant to this Authorization may be	be subject to re-	disclosure by the recipient and no longer prote	ected by F
privacy regulations. By authorizing this release of information, my healthcare and payn	nents for my he	althcare will not be affected if I do not gion	
this Authorization form.	none for my no	attioare will not be affected if I do not sign	
I have been offered a copy of this signed Authorization form.			
If this Authorization is for Marketing, add the following:] I have b	een informed th	nat Darke County General Health	
District will/will not receive financial or in-kind compensation in ex			
escribed above.			
/_OR		/	
(SIGNATURE OF PATIENT) (DATE) (PARE)	NT/LEGAL GU	ARDIAN/AUTHORIZED PERSON) (DAT	ĒE)
	OFFICE USE O	ONLY	
DATE REQUEST FILLED: FORM OFIDENTIFICATION:	BY:		

E-Mail-darkcohd@odh.ohio.gov • Web Site-www.darkecountyhealth.org