

Darke County General Health District

Jordan Francis, MPH, 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: ${(Mo)} {(Day)} {(Yr)}$				
ADDRESS:		CITY:	STATE:	ZIP:
DAY PHONE:	EVI	ENING PHONE:		
I hereby authorize the Darke County Health D	epartment to releas	e/obtain my health	n information to the following	ng agency or person:
☐ OBTAIN INFORMATION FROM		☐ OBTAIN REQUESTED INFORMATION FROM		
OR ☐ RELEASE INFORMATION TO		OR SEND REQUESTED INFORMATION TO		
me:				
		300 Garst Avenue		
ess: State: Zip:			Greenville, OH 45331	
y: State Fax:	Z.ip	Attention:		
nie rax.		At		
HEALTH INFO	RMATION TO BE	E RELEASED O	R RESCINDED	
I specifically authorize release			Rescind dat	e
Immunization records				
Entire Medical Record, OR (chec	k appropriate box	(s)		
History and physical exam				
Progress notes				
Lab, x-ray reports				
Mental health (including psychot	herapy notes)			
Consultations				
HIV related information (AIDS) r	related testing)			
Animal Bite Report				
Other:				
This Authorization is made for the following purpose:			At my request;	or
Specify:				
 This Authorization will expire six years from I may revoke this Authorization at any time b 	this date or on:	numtry Compand Hool	th District in remiting and it re	vill ha affaativa on tha
date notified except to the extent that Privacy				
3. Information used or disclosed pursuant to this	S Authorization may l	be subject to re-disc	closure by the recipient and n	o longer protected by
Federal privacy regulations.				
4. By authorizing this release of information, m	y healthcare and payr	nents for my health	ncare will not be affected if I	do not sign
this Authorization form.				
5. I have been offered a copy of this signed Aut6. [If this Authorization is for Marketing, add th		seen informed that	Dorka County Ganaral Hault	h
District will/will not receive financial or in-k				
described above.	ma compensation in c	exchange for using	or discrosing the nearth infor	munon
/	OR			_/
(SIGNATURE OF PATIENT) (DA		ENT/LEGAL GUAR	RDIAN/AUTHORIZED PERSO	ON) (DATE)
			LY	

300 Garst Avenue Greenville, OH 45331

Telephone: 937-548-4196

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

