AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient information

Patient name: _____ Date of birth: _____

Street address: _____ Home phone: _____

City/State/ZIP: _____ Cell phone: _____

Authorization *(Check one.)*

☐I authorize DeKalb Public Health to disclose my protected health information to the following healthcare facility, organization or individual.

☐I authorize the following healthcare facility, organization or individual to disclose my protected health information to the DeKalb Public Health.

Facility name: _____ Phone: _____

Street address: _____ Fax: _____

City/State/ZIP: _____ Email: _____

Information to disclose *(Check one.)*

☐Date last seen and 2 years prior

☐Date(s) seen from _____ to _____

☐Specific information:

_____

Purpose of disclosure *(Check one.)*

☐Insurance

☐Continuation of care

☐Personal

☐Other: _____

State and federal laws also protect the following particularly sensitive information. If any of these applies to you, indicate whether you authorize the information to be released. *(In each row that applies to you, check "yes" or "no.")*

Alcohol, drug or substance abuse records	☐Yes	☐No
HIV/AIDS records	☐Yes	☐No
Mental health records	☐Yes	☐No
Genetic records	☐Yes	☐No

Acceptable disclosure format, instead of paper *(Check one or both.)* ☐ Fax ☐ Email

☐By checking this box (or these boxes), I acknowledge that I understand that DeKalb Public Health cannot guarantee the safety of faxing or emailing protected health information. I understand that these transmissions are not totally secure and could be monitored, reviewed or intercepted by unauthorized individuals.

By signing this form, I understand that:

- Requests for paper copies of medical records are subject to copying fees.
- Only records originated by the DeKalb Public Health will be shared, unless otherwise requested.
- I am not required to sign it and my treatment, payment, enrollment, or eligibility for benefits will not be affected by whether I sign this form.
- Any disclosure of information carries with it the potential for unauthorized redisclosure and, if this occurs, my information may not be protected by federal confidentiality rules.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and sent to: Medical Records Administrator, DeKalb Public Health, P.O. Box 987, Decatur, GA 30031.
- Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If none is specified, this authorization will expire one year from the date signed.

_____

Signature of patient or authorized representative Date

If applicable: Name of authorized representative: (*Please print.*) _____