

TUSCOLA COUNTY HEALTH DEPARTMENT

Phone: 989-673-8114

1309 Cleaver Road, Suite B, Caro, MI 48723-9135

Fax: 989-673-7490

www.tchd.us

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Client Name _____ Date of Birth _____

Client Address _____ I.D. # _____

I authorize _____ to release the information contained in my medical records, including but not limited to: Information about communicable diseases and serious communicable diseases and infections, as defined by statute and infections, as defined by statutes and Michigan Department of Public Health rules. (This includes venereal diseases ("VD"), tuberculosis ("TB"), hepatitis B, Human Immunodeficiency Virus ("HIV"), Acquired Immunodeficiency Syndrome ("AIDS"), and AIDS related complex ("ARC"), or other as described.)

1) Specific type of information to be released: _____

2) Name and address of person/facility receiving information: _____

3) Purpose and need for such release: _____

I understand that this consent can be revoked in writing at any time by completing the TCHD Authorization Revocation form, except to the extent that the Health Department has taken action in reliance on the authorization. Without expressed written revocation by me, this consent expires on:

this date: _____ or when the following event has occurred: _____

I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization. Without a signed authorization, no protected health information will be released unless authorized under the Health Insurance Portability and Accountability Act and noted in the Tuscola County Health Department Notice of Privacy Practices. If you authorize disclosure of protected health information to an entity not required to comply with Health Insurance Portability and Accountability Act, there is a potential that your protected health information will no longer be protected by the privacy rule. I have read and understand this information. I have received a copy of this form and I am the client or am authorized to act on behalf of the client to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

Client Signature/Date

Witness Signature/Date

The client is a minor, _____ years of age/or is unable to sign because: _____

Personal Representative's Signature/Date

Witness Signature/Date

Relationship to client and representative's authority to act on behalf of client: _____