Ware County Board Of Health
DPH Form GC-00901C

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL/PATIENT	
DATE OF BIRTH	
ADDRESS	**CITY/STATE/ ZIP**

1. I hereby voluntarily authorize _____ to disclose the medical information indicated below to _____.

2. The purpose for this disclosure is for _____.

3. The information to be disclosed is:

- ☐ Entire Medical Record
- ☐ Only medical information from the period _____ to _____
- ☐ Other (specify) _____

If you would like any of the following sensitive information disclosed, please indicate with a check mark below:

- ☐ Alcohol/Drug Abuse Treatment
- ☐ HIV/AIDS-related Treatment
- ☐ Mental Health (other than psychotherapy notes*)

4. This authorization shall become effective immediately and shall remain in effect until _____ (date) or for one year from the date of signature if no date is entered.

I understand that I may revoke this authorization in writing at any time prior to the release of information from DPH, and that revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

I understand that my eligibility for benefits, treatment, or payment is not conditioned upon my provision of this authorization.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act.

_____ Print Patient's Name

_____ Patient's Signature

_____ Print Authorized Representative's Name (if applicable)

_____ Authorized Representative's Signature (if applicable)

_____ Date

**Psychotherapy notes* means notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. 45 C.F.R. 164.501.

[DPH Form GC-00901C (Rev. 7.2.2013)]