Hancock Public Health

7748 CR 140, Findlay, Ohio 45840
Ph. 419-424-7441
Fax 419-424-7189

AUTHORIZATION TO RELEASE RECORDS OF INDIVIDUAL OTHER THAN PARENT/GUARDIAN OR PATIENT

I hereby ( ) request ( ) authorize Hancock Public Health (HPH) to ( ) obtain ( ) disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke the authorization in writing addressed to the Privacy Officer at the address above. This authorization may not be revoked where HPH has reasonable acted in reliance hereupon.

The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

I, _____ (must show copy of I.D.) am the patient, or parent/legal guardian of _____, born _____ and am providing signed consent to release the following records of the patient to _____ (Must provide copy of I.D. @ time of release)

Relationship to patient: _____

This authorization is effective from _____ to _____

- **NOT to exceed 1 year**

PRINT Patient/Parent or Legal Guardian Name: _____

Signature of Patient/Parent or Legal Guardian _____

Description of information being disclosed:

☐ Complete Health Record ☐ Immunization Record ☐ TB Test Results

☐ Consultation Reports ☐ Nurses Notes ☐ Laboratory Tests

☐ BCMH Records

Other: _____

Party receiving this request: _____
(Hancock Public Health/ Employee's name)

Additional information can be found in the Notice of Privacy Practices.
- PROVIDE COPY TO INDIVIDUAL **AND** ORIGINAL TO FILE –