Canton City Public Health

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Client: ____ DOB: ________________

Address: ____ Telephone: ____________

The following programs are authorized to exchange health information as noted below:

____

CCPH Program Authorized to Disclose/Exchange Information

____

Authorized Individual/Organization to/from Whom Information is Disclosed/Exchanged

Purpose of Disclosure:

☐ To coordinate treatment

☐ Assessment information for treatment planning

☐ Information for ongoing treatment

☐ Other purpose:

____

Information to be Disclosed:

☐ Lab Results

☐ Progress Notes

☐ Prenatal Care

☐ Diagnosis

☐ Response to Treatment

☐ Treatment Plans

☐ Other Information (specify):

____

Information which will NOT be Disclosed:

☒ HIV/AIDs Testing or status

☐ Other Information (specify):

____

Time Period to be Disclosed: [ ] information from the current/most recent admission/treatment episode, [ ] information for the period of: __________ to __________

This authorization expires in 60 days, unless an earlier date is specified here: ____________

1. I understand that CCPH may not condition treatment on my providing authorization for the requested use or disclosure and that I MAY REFUSE TO SIGN THIS AUTHORIZATION.
2. I understand that I may revoke this authorization by written request at any time, except to the extent that CCPH has already acted on it.
3. I understand that the recipients of this information may not be obligated to follow the federal privacy regulations, and potentially could re-disclose this information.

This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

________________________________ __________ _____________________ ____________

Signature of Client or Legal Representative Date Signature of Witness Date

Printed Name: __________________________ Relationship to Patient/Authority: _______________

Legal Notice to the Recipient: This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

I hereby revoke my consent: ____________________________________ ____________________

Signature Date