Genesee County Health Department
Authorization for the Use and Disclosure of Individually Identifiable Health Information

Date:_____ Social Security Number:_____

Name of client:_____ Date of birth:_____

Address:_____

_____

Any previous name:_____

I hereby knowingly and voluntarily authorize the release of information contained in my client records to the individuals or organizations listed below, under the conditions listed below.

Individual/organization <u>RELEASING</u> information *(be specific)*:

☐ Genesee County Health Department

☐ Other _____

_____

_____

_____

Individual/organization <u>RECEIVING</u> information *(be specific)*:

☐ Genesee County Health Department

☐ Other _____

_____

_____

_____

Information to be disclosed *(include type of information and date (s) of service)*:_____

_____

_____

Purpose and need for the disclosure *("at the request of the individual" is sufficient):*

_____

This authorization is valid for one year from the date signed unless otherwise revoked, or an alternate event, condition, or date is specified:

_____

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I understand that:

- I may refuse to sign this authorization. However, if I do not sign this authorization, my request to release information will not be fulfilled.
- I may look at or copy the information ("PHI") to be used or released.
- If the Health Department is requesting the authorization for its own use, it will not condition services, payment, enrollment, or eligibility of benefits on my signing this authorization.
- I may obtain a copy of my protected health information, except for:
  - Psychotherapy notes;
  - Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and;
  - Protected Health Information maintained by the Health Department that is (1)subject to the Clinical Laboratory Improvements Amendments (CLIA), to the extent the provision of access to the individual would be prohibited by law; or (2) exempt from CLIA, pursuant to 42 CFR 493.3(a)(2).
- The information used or disclosed pursuant to this authorization may be redisclosed by the recipient and no longer be protected by state and federal confidentiality laws.
- I have the right to revoke this authorization by submitting a request in writing to the Privacy Officer unless either of the following conditions exists:
  - The Health Department has taken action in reliance thereon.
  - This authorization was obtained as a condition of obtaining insurance, and a law provides the insurer the right to contest a claim under the policy.

_____

Signature of the individual Date

_____

Signature of witness Date

Brief description of person's authority to sign authorization if the authorization is signed by someone other than the client (such as a parent, personal representative, or guardian):

_____

For Administrative Use

Request reviewed by: _____ Date:_____
(Initial of supervisor or staff person)

Copy of authorization provided to client Date:_____

Authorization included in chart Date:_____