LENAWEE COUNTY HEALTH DEPARTMENT

1040 S WINTER STREET – SUITE 2328
ADRIAN, MI 49221
PHONE: 517-264-5226 FAX: 517-264-0790

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

CLIENT NAME: _____
LAST NAME FIRST NAME MI Maiden/Other

DOB: _____/_____/_____ PHONE: ( ) _____ - _____

Address: _____

City:_____ State:_____ Zip Code:_____

I HEREBY AUTHORIZE THE LENAWEE COUNTY HEALTH DEPARTMENT TO:

☐ **GET INFORMATION FROM** ☐ **RELEASE MY HEALTH INFORMATION TO**

Name: _____
Address: _____
City: _____ State:_____ Zip Code: _____
Phone: ( ) _____ - _____ FAX: ( ) _____ - _____

PLEASE FAX/SEND MY INFORMATION TO THE LENAWEE COUNTY HEALTH DEPARMTENT AT (517) 264-0790

HEALTH INFORMATION TO BE RELEASED (I specifically authorize release of the following information (as checked):

☐ STI ☐ HIV (AIDS related testing) ☐ Communicable Disease
☐ TB testing/treatment ☐ Lead test results ☐ Immunization records
☐ Hearing/Vision test records ☐ CSHCS ☐ WISEWOMAN
☐ ALL medical records (from _____ thru _____) ☐ OTHER _____

Family Planning Program/Breast & Cervical:

☐ Last pap test results and any abnormal pap test results ☐ Copy of last complete exam ☐ Copy of breast evaluation
☐ Date of last depo-provera injection ☐ Notes of evaluation for hormonal birth control ☐ Colposcopy/biopsy results
☐ Lab results ☐ Notes of referral evaluation ☐ OTHER _____

THIS AUTHORIZATION IS MADE FOR THE FOLLOWING PURPOSE:

☐ **AT MY REQUEST** ☐ **AT THE REQUEST OF (specify):** _____

CONDITIONS OF AUTHORIZATION:

1. This authorization will expire one year from the date of signature OR on _____.
2. I may revoke this authorization at any time by notifying the Lenawee County Health Department, in writing, and it will be effective on the day notified except to the extent that the Lenawee County Health Department has already acted upon such authorization.
3. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal HIPAA Privacy regulations.

_____ _____
SIGNATURE OF PATIENT (DATE) AUTHORIZED PERSON & RELATIONSHIP (parent/guardian) (DATE)

_____
WITNESS SIGNATURE (DATE)

FOR OFFICE USE ONLY
Date Request Completed: _____ ___ By: _____