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KENT COUNTY HEALTH DEPARTMENT

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Adam London, MPA, RS, DAAS
Administrative Health Officer

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ (client or parent/guardian), hereby authorize
(Please print)
_____ Division of the Kent County Health Department, to release information and/or exchange information with the person/s and/or organization listed below, health information contained in the client records of:

Name: _____ Date of Birth: _____
(Last) *(First)* *(Middle)*

□ To -or- □ From: Kent County Health Dept. □ To -or- □ From: _____
(Please Select) *(Please Select)* _____

The information to be released or exchanged is limited to the following records specified by description and date.
_____
_____

The information to be released or exchanged is to be used ONLY for the following authorized purpose:
_____
_____

All records pertaining to Mental Health/Psychological Testing, Chemical Dependency, HIV/AIDS services which may include HIV testing, and information related to treatment of sexually transmitted diseases, tuberculosis, or other communicable disease as specified by the Michigan Department of Community Health will not be released unless specifically authorized by signature below.

□ **Mental Health** _____ ***(Signature)*** **Date:** _____
□ **Chemical Dependency** _____ ***(Signature)*** **Date:** _____
□ **HIV/AIDS** _____ ***(Signature)*** **Date:** _____
□ **STD/TB/CD** _____ ***(Signature)*** **Date:** _____

This information is protected by federal law (42 CFR, Part 2) which prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT SUFFICIENT for the purpose.

I understand that I may withdraw this authorization at any time by notifying the agency holding my records. This authorization will expire on the following event/condition or, no longer than six months from today's date. I have been provided with a copy of this authorization.

Event Condition: _____ Expiration Date: _____

Signed: _____ Date: _____
□ Client -or- □ Parent -or- □ Guardian *(Please Select)*

Address: _____

Witness: _____ *(Signature)* Date: _____

All information will be treated confidentially and will be for professional use only. Further release of information so disclosed is prohibited unless consistent with the authorized purpose stated above. Any persons receiving such information shall be so advised (Sec. 748, Mental Health Code).