FLOYD COUNTY HEALTH DEPARTMENT

1917 Bono Road
New Albany, Indiana 47150-4607
Telephone (812) 948-4726
Fax (812) 948-2208
www.floydcountyhealth.org

MEDICAL RECORD RELEASE AUTHORIZATION FORM

I authorize the Floyd County Health Department to disclose information to:

_____

_____

_____

_____

Telephone: _____

- o The Floyd County Health Department has permission to fax my health information to:

_____

Please disclose the following information:

- o Vaccination Record
- o Other (please specify) _____

Reason or Purpose for this Disclosure:

- o Personal Use
- o School Requirements
- o Physician / Continuity of Care
- o Other (please explain) _____

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization the I must do so in writing. I understand the revocation will not apply to information that has already been released prior to receipt of this revocation. Unless otherwise revoked, this authorization will expire on _____. I understand that authorizing this disclosure is voluntary. I can refuse to sign this authorization. I understand any disclosure carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

_____ _____

Patient Name (Please Print) **Birth Date** **Daytime Telephone**

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

FCHD Representative Date