Authorization for Release of Medical Information

Authorization for use/or disclosure of Protected Health Information.

I hereby authorize the_____Howard County Health Department Nursing Division
120 E. Mulberry ST.
Kokomo, IN 46901
765-456-2408

To release information to _____
(Name of recipient)

Address

_____ _____ _____ _____
City State Zip Telephone

Name of Client: _____ **DOB**_____

Check the box and initial to specify which type of information is to be disclosed.

- ❑ Medical Information _____
- ❑ Vaccination records _____
- ❑ Lab Results _____
- ❑ Other _____

Specify the records to be disclosed:

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____.

Revocation: This authorization is also subject to written revocation by the client at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.
Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorized Representative or Client:

Signature: _____

Name_____
Print
Relationship to Patient_____

Date :_____

Witness:

Signature:_____

Name _____
Print
Date:_____