JACKSON COUNTY HEALTH DEPARTMENT
P.O. Box 307 • Murphysboro IL 62966 • Phone 618/684-3143 • FAX 618/687-1255

Authorization Form for Release of Protected Health Information

I, _____, hereby authorize Jackson County Health Department
Name of Client or Personal Representative

□ to obtain the information listed below from: □ to release the information listed below to:

_____
Name of Person to Receive/Release Information

_____
Street Address City State Zip

from the designated record set of _____ whose birth date is _____.

The following information shall be released (mark all applicable):

□ Child health exam
□ Family Planning records
□ STD testing and treatment records
□ Immunization records
□ Genetic information / treatment records
□ Laboratory results (specify _____)
□ Other (specify _____)
□ Blood lead test results
□ TB care and treatment records
□ HIV/AIDS records
□ Sexual assault information

The purpose of the authorization is:

□ at the request of the individual or personal representative □ for referral to another health care provider
□ other: _____

The information should be released for the following time period: from _____ to _____ .

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that if the health department has already used or released my health information in reliance on this authorization, I cannot revoke the authorization. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by law.

I understand that the health department may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration listed below, or until I revoke it in writing by delivering a written revocation to the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

This authorization for release of protected health information terminates on _____
(Date)

_____ _____
Signature Date

If you are the personal representative of the client, please specify relationship to the client: _____

_____ _____
Staff Signature Date

cc: Client (or personal representative) 8/13