



Authorization to Disclose Health Information

Name _____ Date of Birth _____

I, _____, hereby authorize the Ohio Department of Health to
(Client, Patient or Personal Representative)
disclose specific and identifiable health information from the records of the above named person to *(Recipient Name/Address/Phone/Fax)*:

for the specific purpose(s) of:

Specific information to be disclosed:

This authorization will expire on the following date, event or condition:

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time. I further understand that any action taken by the Ohio Department of Health in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

(Signature of Client/ Patient) *(Date)* *(Witness-If Required)*

(Signature of Personal Representative) *(Date)* *(Relationship/ Authority)*

NOTE: This Authorization was revoked on: _____
(Date) *(Signature of Staff)*