COLUMBUS HEALTH DEPARTMENT
240 Parsons Avenue, Columbus, Ohio 43215

Clinic Fax Number: 614-645-_____ **Clinic Phone Number: 614-645-_____**

AUTHORIZATION TO RELEASE INFORMATION

I, _____/_____/_____(_____), _____,
last name *first* *middle* *maiden name* *date of birth*

am allowing _____to release the following
agency or person releasing information

information about my health care to _____

_____
agency or person receiving information

Information to be released – Check all that apply:

☐ Immunization record ☐ Radiology report ☐ PPD result in mm ☐ Lab results **with** HIV
☐ Mental health history ☐ Medical health history ☐ Discharge summary ☐ Progress notes
☐ HIV/AIDS history ☐ Diagnosis ☐ Lab results **without** HIV
☐ Alcohol/drug abuse history ☐ Other_____

Information is to be released for the purpose(s) of - Check all that apply:

☐ Continuity of care ☐ Making a referral ☐ Personal use
☐ Reimbursement/benefits ☐ Legal ☐ Informing referral source
☐ Other _____

The above items may include information about mental health, alcohol/drug abuse, and/or HIV/AIDS.

Amount of information to be released includes – Check one:

☐ last service date ☐ all service dates ☐ information from date _____*date*_____ through _____*date*_____

Columbus Health Department MAY NOT deny treatment based on whether you sign this authorization.

This information is not re-released unless a court order forces the release.

I understand that I may cancel this authorization at any time by sending a written request to the Columbus Health Department. This request will not apply to information already released.

This authorization will remain in effect for one year after the date I sign it unless another date or event is specified here: _____

Signature:_____Date:_____

Relationship if other than self:_____ Witness:_____

I HEREBY CANCEL THE ABOVE AUTHORIZATION AS OF THIS DATE:

Signature: Date:

Name of interpreter, if used _____

Redisclosure of alcohol and drug abuse information: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987: 52 FR 41997, November 2, 1987)