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)*

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PLEASE DO NOT FORGET TO INCLUDE A PHOTOCOPY OF A GOVERNMENT-ISSUED ID