COBB & DOUGLAS PUBLIC HEALTH
Healthier lives. Healthier community.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION	Name:_____ Date of Birth:_____ Address:_____ Phone:_____ City:_____ State:_____ Zip: _____
SENDING ORGANIZATION (Name of the person or facility that will be releasing your information)	Name of Person or Facility: _____ Address:_____ Phone:_____ City:_____ State:_____ Zip:_____ Fax:_____ We do not fax to personal fax numbers
RECEIVING PERSON/ ORGANIZATION (Name of the person or facility that will be receiving your information)	Name of Person or Facility: _____ Address:_____ Phone:_____ City:_____ State:_____ Zip:_____ Fax:_____ We do not fax to personal fax numbers
INFORMATION TO BE RELEASED	***Check the Types of Information to be Released:*** ___ Entire Medical Record ___Immunization Record ___Lab Reports ___ Only medical information from the period_____ to _____ ___ HIV/AIDS Related Records ___ Mental Health (other than psychotherapy notes) Records ___ Other (specify) _____
RELEASE INSTRUCTIONS	**Delivery Method:** ___ Mail (to address listed above for receiving person) ___ Pick-up (Recipient Name:_____) ___ Fax (to receiving person listed above) Fax # _____ ___ Email (to receiving person listed above) Email Address _____
PURPOSE OF RELEASE	___Continuing Care____Insurance Reimbursement____Legal Action/Review____Personal Use ___Social Security Disability Determination ___Other: _____

I acknowledge and understand the following statements:

- This authorization is effective immediately upon my signature and expires one year from the date of signature unless an alternative date is entered here: _____
- I may refuse to sign this authorization and that it is strictly voluntary and that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke my consent at any time by submitting my revocation request in writing to the Cobb & Douglas Public Health (CDPH) Medical Records department. The revocation of this request will not affect any health information disclosed prior to CDPH receiving my written notice.
- I understand that information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

Signature

Patient/Legal Guardian Signature	Date	Authority to act on behalf of patient (attach documentation)

FAXED OR MAILED REQUESTS TO CDPH MUST BE SENT WITH A COPY OF PHOTO IDENTIFICATION

www.cobbanddouglaspublichealth.org