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

_____
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
☐ Blood lead test results
☐ Family Planning records
☐ TB care and treatment records
☐ STD testing and treatment records
☐ HIV/AIDS records
☐ Laboratory results (specify _____)
☐ Immunization records
☐ Other (specify _____)

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 above, or until I revoke it in writing by delivering a written revocation to the health department.

_____ _____
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) 4/04