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Summit County Public Health

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Birthdate: _____

I hereby authorize Summit County Public Health to release the records described below.

Obtain Information From:

Agency: Summit County Public Health

Phone number: 330-375-2984

Information to be shared: _____

Reason for disclosure: _____

Release Information To:

Agency/Person Name: _____

Address: _____

Email: _____ Phone _____ Fax _____

I have been offered the District's Notice of Privacy Practices (<https://scph.link/NPP>) and understand that these explain how the medical information of the patient may be used and disclosed. I understand and acknowledge that this Authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse, (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV/Acquired Immune Deficiency Syndrome AIDS) test results or diagnoses (ORC3701 24.3). I understand the 42 CFR Part 2 protects my records and they cannot be shared without my written consent except as provided by law. Any information disclosed that is not protected by 42 CFR Part 2 or other law may be subject to re-disclosure by the recipient. All disclosures will be accompanied by the following statement: "42 CFR Part 2 prohibits unauthorized disclosure of these records". I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned upon the execution of this release except that if I am referred by the criminal justice system I must execute a release to provide the appropriate persons with appropriate information about my substance abuse records. I understand that I may revoke this authorization at any time by contacting the SCPH Privacy Officer at 330-923-4891, except to the extent that SCPH has relied on this authorization. I understand I have a right to an accounting of disclosures.

Signature of Client or Client's Representative: _____

Client's Representative (print): _____

Authority of Representative: _____ Date: _____

(your consent will automatically expire 90 days from the date of signature)

If choosing to REVOKE, call 330-375-2984 to make this request.