ONONDAGA COUNTY HEALTH DEPARTMENT

AUTHORIZATION FOR USE OR DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Policy #311
ATT: A
4/7/03

Program Name:_____

Program Address:_____

Program Phone:_____Fax:_____

_____ _____ _____ _____

Name of (Client/Patient/Child) DOB SS# (Other)

I allow ONONDAGA COUNTY HEALTH DEPARTMENT to:

RELEASE TO: _____ OBTAIN FROM: _____

_____

_____

_____

The following information:

_____

_____

_____

Reason:

_____

_____

RELEASE TO: _____OBTAIN FROM: _____

_____

_____

_____

The following information:

_____

_____

_____

Reason:

_____

_____

I understand that I can take back this permission unless the information has already been given out. To take back the permission, I must send a letter to the Health Department program listed at the top of this page. Any records given out using this signed permission may be sent somewhere else by the agency we give it to. If they send it on, it may not be protected by the same laws.

You will not be refused any service by the Onondaga County Health Department if you decide not to sign this form. The line below lists anything that will not be given out.

_____

I understand that a copy of this can be used the same way as this form.

This permission ends _____ from the date signed by the (client/patient/parent/guardian).

_____ _____

(Client/Patient/Parent/Guardian) Witness

_____ _____

Relationship to (Client/Patient/Child) Date Date