Department of Human Resources, Division of Employee Benefits
COUNTY OF SUMMIT
1180 S. MAIN STREET, ROOM #378
AKRON, OHIO 44301
330.643.8763 ◆ FAX: 330.643.8625

# AUTHORIZATION RELEASE FORM

ID NUMBER

**THIS IS A CONFIDENTIAL INTERNAL DOCUMENT**

I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.

| ENROLLEE'S NAME | DATE OF BIRTH |
|---|---|
| ENROLLEE'S SOCIAL SECURITY NUMBER | |

Title and name of person releasing my health information:

______________________________

Person(s) receiving my health information [Example: "My employer"]:

______________________________

Description of information being disclosed for the following date(s) of service:

______________________________

- ☐ Complete Health Record
- ☐ History and Physical Exam
- ☐ Emergency Department Record
- ☐ Abstract/Pertinent Information
- ☐ HIV/AIDS information
- ☐ Drug and Alcohol treatment information
- ☐ Other: ______________________________
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ Progress Notes

Purpose of the Disclosure [Example: "At the request of the enrollee"]:

______________________________

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires in 60 days. Otherwise, you may select either of the following expiration events:

☐ 1 year from the date in which I, or my legal representative, signs this authorization;

☐ Upon the happening of the following event:______________________________
[Example: "Upon release of the above records"].

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Right to Revoke: I understand that I may revoke this authorization at any time by providing written notice to the Privacy Officer at ______________________________________________.
I understand that my revocation won't have any affect on any actions taken by the organization before they received the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy.

I understand that the organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization.

I understand that I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.

| ENROLLEE/LEGAL REPRESENTATIVE SIGNATURE | DATE *(YEAR/MONTH/DAY)* |
| --- | --- |
| | |

If signed by the enrollee's legal representative:

| PRINTED NAME OF REPRESENTATIVE |
| --- |
| RELATIONSHIP TO THE ENROLLEE |

***PROVIDE COPY TO THE ENROLLEE AND MAINTAIN A COPY IN THE RECORD***