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: ________	RELEASE TO: ________OBTAIN FROM: ________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
The following information:	The following information:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
Reason:	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