ONONDAGA COUNTY HEALTH DEPARTMENT

AUTHORIZATION FOR DISCLOSURE OF

PROTECTED HEALTH INFORMATION - ONE TIME USE

Name of Patient	**Date of Birth**
Address	**Contact Phone Number**

I voluntarily authorize the disclosure of information from my health record as follows:

The information is to be disclosed FROM:	**And is to be provided TO:**
Name of Facility/Organization Lead Poisoning Prevention Program	**Name of Facility/Organization**
Address 421 Montgomery St., Syracuse NY 13202	**Address**
Fax Number 315-435-3720	**Fax Number**

The Purpose or need for this disclosure is:

- ☐ Ongoing Medical Care
- ☐ Personal Use
- ☐ Employer
- ☐ Other (specify) _____

The information to be disclosed from my record includes (check appropriate boxes):

- ☐ Entire Record
- ☐ Only information related to (specify): _____
- ☐ Only from this time period:
  From_____To_____
- ☐ Other (specify)

If you would like any of the following sensitive information disclosed, you must check the appropriate box below:

- ☐ HIV/AIDS-related testing and/or treatment

I understand that I can take back this permission unless the information has already been provided. I can cancel permission by writing to the Onondaga County Health Department, Attn: Compliance Officer, 421 Montgomery St, Syracuse, NY 13202.

I understand that, with some exceptions, health information provided to another party may be re-disclosed by that party. If I am authorizing the release of HIV/AIDS related information, alcohol or drug treatment, or mental health treatment information, the recipient is not allowed to redisclose or share this information or use for any other purpose without my explicit authorization unless permitted by federal or state law.
I understand that I will not be refused any service by the Onondaga County Health Department if I decide not to sign this form.

This authorization is for a one-time release of information. It will terminate once the records have been received by the facility/person indicated above.

SIGNATURE:	**DATE:**
PRINT (WHO IS SIGNING)	**RELATIONSHIP TO PATIENT:**