AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Benzie-Leelanau District Health Department (BLDHD)

Directions: *Type or Print all requested information, with exception of signatures on Page 2.*

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)			Individual's ID Number (Medicaid, SSN, MRN, Other)
Street Address			Individual's Date of Birth / /
City	State	ZIP Code	Phone ( ) -

I AUTHORIZE Benzie-Leelanau District Health Department (BLDHD)TO:

□ **SHARE MY HEALTH INFORMATION WITH** □ **OBTAIN MY HEALTH INFORMATION FROM:**

List the amount or type of information you would like to share in the section below.
For example, you can say all my health information or list certain types of information you would like to share.

Type of Information: Time Period Covered:

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Type of Information: Time Period Covered:

BLDHD MAY SHARE OR OBTAIN (as indicated above) MY HEALTH INFORMATION WITH THE FOLLOWING PERSON OR ORGANIZATION:

Name of Person/Organization

Street Address

City, State, ZIP Code

( ) - ( ) -

Phone Number Fax Number

BLDHD WILL SHARE OR OBTAIN MY HEALTH INFORMATION FOR THE FOLLOWING REASON:

For example, to discuss my health care benefits or at the request of the individual.

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BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- **Information regarding communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information above _____.**
- This form does not give my consent to share psychotherapy notes as defined by federal law.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to the BLDHD HIPAA Compliance Officer and include a copy of the front of this form.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this signed authorization. If I have not previously revoked this authorization, it will expire on: *(list a date, event or condition)*

_____

Date, Event or Condition
(Authorization will expire one year from the signature date if you leave this section blank.)

Signature of Individual or Legal Representative	Date / /
Name of Individual or Legal Representative	
Legal Representative's Relationship to Individual: □ Parent □ Guardian □ Other_____ *If not a Parent then a copy of legal document stating relationship status is required prior to releasing Protected Health Information & should be filed with this form. Authorization expires when custody changes and new Authorization to Disclose must be obtained.*	

BLDHD USE ONLY

This authorization was revoked:

/ /

_____

Signature Date

Services are offered without regard to sex, race, religion, or sexual orientation.