Authorization for Release of Protected Health Information

330 Vermont St. Quincy, IL 62301
P. (217) 222-8440 F. (217) 222-8478 www.co.adams.il.us

I, ____, hereby authorize the **Adams County Health Department**
(Name of client, parent, or legal guardian)
to RELEASE or OBTAIN information on self or the client(s) listed below regarding:

☐ Immunizations ☐ Lead/**Hemoglobin Testing (Required for WIC)** ☐ Measurements ☐ Family Case Management
☐ Well Child Visit ☐ Tuberculosis Screening ☐ Other: _____________________

First and Last Name	Date of Birth

Information may be released to:

☐ Doctor's Office: ____
☐ School: ____
☐ Employer: ____
☐ Covered Bottoms Diaper Bank
☐ Adams County IRIS Referral Network for additional supportive services
☐ Cornerstone First Steps child development program

This authorization for release of protected health information is from today's date_______________ until 18th birthday or 10 years from current date.
(Current Date)

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that if the health department has already used or released my health information in reliance on this authorization, that I cannot revoke the authorization. If I refuse to sign this authorization, the above–described health information will not be disclosed except as provided by law.
I understand that this authorization for release of information is voluntary, and the health department may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.
I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration stated above, or until I revoke it in writing by delivering a written revocation the health department.
I understand the nature and consequences of receiving services and they will be explained to me. I understand the health department is already authorized to use the information gained during treatment to bill me or any other potential source of reimbursement, such as government programs in which I am enrolled or qualified services. I also hereby acknowledge that I may receive a copy of the "Joint Notice of Privacy Practice" upon request by the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

Signature: ____ Date: ____

FOR STAFF USE ONLY
Identity of person making request for release of information was verified by: ☐ Driver's License ☐ Birth Certificate.
Check if any of the following apply:
☐ Parent or Guardian of minor ☐ Guardian with power to make health care decisions.
☐ Power of Attorney for Health Care ☐ Mental Health Treatment Preference Declaration Agent ☐ Health Care Surrogate