



# JEFFERSON COUNTY DEPARTMENT OF HEALTH

1400 6th Avenue South | Birmingham, AL 35233 (205) 933-9110 | www.jcdh.org

*Serving Jefferson County Since 1917*

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

*All sections must be completed*

Personal Information About Patient						
Last Name		First Name		M.I.	Date of Birth	Age
JCDH Medical Record Number	Street address			Telephone Number		
City	County	State		Zip Code		

### RELEASE INFORMATION TO:

Name:
Address:
Phone:
Email:
Fax Number:

### INFORMATION TO BE RELEASED BY:

Name: <b>ATTN: RELEASE OF INFORMATION (ROI)</b> Jefferson County Dept of Health
Address: 1400 SIXTH AVENUE SOUTH BIRMINGHAM, AL 35233
Phone: 205-930-1491, 930-1378, 930-1019
Email: ROI.INFO@JCDH.org
Fax Number: 205-930-1305

### DESCRIPTION OF INFORMATION TO BE RELEASED:

*Must have dates of service*

<input type="radio"/> Treatment Notes	<input type="radio"/> Immunizations
<input type="radio"/> Test/Lab Results	<input type="radio"/> Demographic Data
<input type="radio"/> Dental	<input type="radio"/> Complete Record
<input type="radio"/> Dental X-rays – Current Only <input type="radio"/> Dental X-rays – All	<input type="radio"/> Other (Provide description)
<input type="radio"/> Partial Record (specific date range)	

### PURPOSE OF INFORMATION TO BE RELEASED:

<input type="radio"/> Continuity of Care	<input type="radio"/> Personal
<input type="radio"/> Changing Doctor/Health Care Practitioner	<input type="radio"/> School
<input type="radio"/> Employment	<input type="radio"/> Legal
<input type="radio"/> Family/Guardian Request	<input type="radio"/> Other (Provide purpose)
<input type="radio"/> Insurance	

I understand that the information in my health records may include information relating to notifiable diseases, sexually transmitted diseases, and acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral and mental health issues, and services/treatment for alcohol and drug abuse.

I hereby authorize the use and disclosure of my individual protected health information (PHI) as described above. I understand that this authorization is voluntary and I may not be denied treatment, payment, enrollment, or eligibility for services based on whether or not I sign this authorization for release of PHI. I understand that if the agency authorized to receive the information is not a health plan or healthcare provider, this information may no longer be protected by federal privacy regulations and is subject to re-disclosure.

I understand that this authorization will expire one year after signature or on \_\_\_\_\_(enter date mm/dd/yyyy). I understand that I may revoke or cancel this authorization at any time by notifying this agency in writing. If I revoke or cancel this authorization, it will have no effect on any disclosures made before the revocation/cancellation.

- Legal Guardians and Patient Representatives must provide proof of their authority to sign for the patient. Examples include birth certificate, Custody Order, Court Order, etc.
- Patients age 14 years and older are required to sign the authorization form. Examples of proof of signature include driver license, school photo ID, non-driver ID or any other ID with signature.

**PATIENT OR NAME OF PERSON AUTHORIZED TO REQUEST DISCLOSURE**

Print Name	Signature	Date

**RELATIONSHIP TO PATIENT (check applicable relationship)**

\_\_\_\_\_ Self      \_\_\_\_\_ Parent      \_\_\_\_\_ Legal Guardian      \_\_\_\_\_ Patient Representative

**WITNESS**

Print Name	Signature	Title

\_\_\_\_\_ Date

*Provide copy to patient/requestor*