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			Apt Number	
City	County	State		Zip Code	

RELEASE INFORMATION TO:

Name:
Address:
Phone:
Email:
Fax Number:

INFORMATION TO BE RELEASED BY:

Name: **ATTN: Release of Information (ROI)** **Jefferson County Department of Health**
Address: 1400 6th Avenue South Birmingham, AL 35233
Phone: (205) 930-1491, (205) 930-1378, (205) 930-1019
Email: ROI.INFO@jcdh.org
Fax Number: (205) 930-1305

DESCRIPTION OF INFORMATION TO BE RELEASED:

Must have dates of service

○ Treatment Notes	○ Immunizations
○ Test/Lab Results	○ Demographic Data
○ Dental	○ Complete Record
○ Dental X-rays – Current Only ○ Dental X-rays – All	○ Reproductive health services, including but not limited to pregnancy, conception, termination or loss of pregnancy
○ Partial Record (specific date range)	○ Other (Provide description)

PURPOSE OF INFORMAITON TO BE RELEASED:

○ Continuity of Care	○ Personal
○ Changing Doctor/Health Care Practitioner	○ School
○ Employment	○ Legal
○ Family/Guardian Request	○ Other (Provide purpose)
○ Insurance	

I understand that the information in my health records may include information relating to notifiable diseases, reproductive health services, 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/cancelation.

- 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 aged 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

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WITNESS

_____	_____	_____
Print Name	Signature	Title

_____
Date

Provide copy to patient/requestor